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ABSTRACT

A study examined the feasibility of using standardized health evaluation, counseling, and rehabilitation to increase employability of welfare recipients and to develop a demonstration model for health service suitable for national implementation in the WIN (Work Incentive Program). Health evaluations of referred welfare clients showed that the commonest health related problems were hypochondriasis, neuroses, obesity, and alcoholism. Clients with remediable health problems were randomly assigned to health intervention and control groups. The health rehabilitation received by those in the intervention group decreased the number of health complaints and reversed hypochondriasis. In addition to other positive findings, welfare grant reduction was substantially greater for intervention than control clients. A series of surveys were conducted to assist in evaluating the project and developing the demonstration model. Finally, the demonstration model was proposed, specifying target population, modes of delivery, staffing, staff training and tasks, location of staff, administrative pattern, process and implementation. (A major portion of this document includes the following appended information: the feasibility study, a comparison of the feasibility and demonstration projects, data tables, client case resumes, survey instruments, report forms, and client charts.) (Author/BM)

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Final Report:

PHYSICAL REHABILITATION AND EMPLOYMENT OF AFDC RECIPIENTS

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16. Abstracts

Aims were 1) to examine feasibility of using standardized health evaluation, counseling and rehabilitation to increase employability of welfare recipients; 2) to develop a demonstration model for a health service suitable for national implementation in the WIN system. Welfare clients were referred from WIN/SAU or from DSS outside the WIN system. Upon health evaluation, commonest health related problems were hypochondriasis, neuroses, obesity and alcoholism. Clients with remediable health problems were randomly assigned to health intervention and control groups. Health rehabilitation decreased the number of health complaints and reversed hypochondriasis. Women with children under 6 were successful in rehabilitation and placement. Welfare grant reduction was substantially greater for intervention than control clients. In the proposed demonstration model, health evaluation will be by a nurse-clinician or M.D. A health counselor/educator, employed by WIN, will provide services including counseling, education, and medical referral. It is proposed that clients receiving health services be in special programs and eligible for special WIN placement until health problems are resolved.

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6. Finding: The kinds of health problems which are amenable to treatment within a health service in the national WIN system are emotional problems and symptoms which result from hypochondriasis, adverse health behavior or medical neglect e.g. headaches, insomnia, excessive tiredness, "bad back", dental decay, as well as acute or chronic diseases if these are not serious, multiple or have advanced to a point of permanent or gross disfiguration.

Implication: The health service should provide health education in addition to health counseling and medical/dental referral.

7. Finding: Health rehabilitation led to a reduction in the number of health complaints cited at the follow-up visits and lessened hypochondriasis. Reduction in hypochondriasis showed a strong relationship to success in employment.

Implication: A most important component of a health service within WIN should be counseling with respect to health perceptions.

8. Finding: The return of AFDC recipients to the labor force through health rehabilitation depends on the initial health assessment and appropriate selection of clients for the program, the skills of the health counselor, the availability of support services and more particularly, the job market.

Implication: AFDC clients should be selected for health services who have the potential for rehabilitation. The health counselor should have skills in health education and counseling as well as a knowledge of locally available health and social support services. Job development appropriate to the needs of clients has to be given priority.

9. Finding: Predictors of success with respect to employment were found to be motivation, compliance, higher IQ, and education, the client being a female head of household with a child under 6 in the home, perception by the client that health does not restrict work, fitness and absence of obesity.

Implication: Priority for health rehabilitation and placement should be given to WIN registrants, including volunteers with these characteristics.

10. Finding: In two project sites, one in a WIN and another in a non-WIN system where AFDC and other public assistance clients were afforded health education, counseling and advocacy, as well as medical/dental care, a positive effect of the program on client placement was obtained in the sample in the non-WIN system because they had less severe health problems requiring treatment and because they were placed in employment appropriate to their mental and physical capacities.

Implication: Success of a health rehabilitation service for AFDC clients with respect to employability depends on supply (that is the characteristics of the target group) and the demand (placement opportunities).

11. Finding: Expenditures for health evaluation and rehabilitation to fit clients for the work force were found to be cost effective over allowing clients to remain on welfare, if health problems are remediated on a long-term basis. This assumes that persons with multiple and severe health problems, unlikely to respond to health intervention, are referred to other governmental programs. The cost of health rehabilitation was significantly exceeded by annualized welfare grant reductions among clients who were successfully placed. Health care other than that provided by health counselors was covered by Title XIX.

Implication: Expenditures incurred for health rehabilitation are justified if long range health and employment goals are to be addressed.

12. Finding: WIN regional directors in supporting our proposal for a health component of WIN saw a need for uniform health evaluations by a WIN oriented provider and health services by a WIN employed counselor.

Implication: The demonstration model should have two components, viz. health evaluation by an assigned M.D. or nurse practitioners who will follow a protocol and health services by a health counselor within the WIN system.

13. Finding: Representatives of agencies in contact with the project [WIN/SAU, WIN/DOL, DSS and NYSES] found the project system of health evaluation superior to existent methods, positive facets being focus on employability, precise diagnoses, information on hypochondriasis and reporting system. Rehabilitation by the project did improve employability according to agency contacts. Disadvantages of the project were WIN system project location, independence from WIN and lack of enforcement powers.

Implication: The demonstration model should maintain present focus but additionally should become a component of WIN and be more accessible to clients.

14. Finding: A theoretical demonstration model for a health component in the WIN system was designed to include evaluation and services. Following consultation with WIN administrative staff, modifications were introduced such that a nurse practitioner or M.D. outside the WIN system would be assigned by contract to carry out health evaluations for WIN and a health counselor/educator would become a WIN staff member to provide health services for WIN clients. Clients provided with health services would be in the special programs category.

Implication: It is the judgment of WIN staff that the demonstration model, as modified, can be incorporated into the WIN system.

15. Finding: It has been found within the WIN system, in different geographic locations, that there are multiple WIN units within counties which would offer comparison groups for implementation of various modifications of the demonstration model. Modifications of the model pertain to presence

or absence of an appointed NP or MD and qualifications/duties of the health counselor within the model, as well as the addition of a community health worker in the unit where there is no appointed MD.

Implication: Comparison of structure (staffing), process (health evaluation/services) and outcome between demonstration models and the classical system can be effected by the proposed design. Comparison of outcome variables should be between localities, between units within a locality (demonstration vs. classical), between demonstration models (demonstration 1 vs. demonstration 2 vs. demonstration 3) and between all units. Criteria of success will be: number of clients placed following health evaluation in special programs; number of clients post health evaluation who received special employment placement; number of clients following health evaluation who register for regular WIN; number of clients who have been in special programs and/or in special placement employment who, at a later date, register for WIN; change in welfare grants; change in size of unassigned recipient pool; and cost benefit analysis.

CONCLUSIONS

Welfare clients who are referred to WIN/SAU with medical problems require a comprehensive and standardized health evaluation to determine the etiology of their complaints, whether or not their health problems would be handicaps in a work environment, and the prognosis for successful rehabilitation with an employment goal. In the Cornell Health Rehabilitation Project, which is described in this report, the most common medical problems considered remediable, which were found among clients, were neuroses, obesity and alcoholism. Hypochondriasis was prevalent. Most clients had social as well as medical handicaps. In view of these findings we consider that health evaluation of welfare clients for WIN should be problem-oriented rather than disease-oriented.

Of the health problems that we encountered among our clients, those that would be most amenable to treatment within a national WIN health service are emotional problems and symptoms which result from hypochondriasis or adverse health behavior. This conclusion has been reached because these were the health problems that responded best to health intervention. It was found that the presence of aversive handicaps such as massive obesity and unattractive appearance associated with dental decay or skin disease as well as communication handicaps such as borderline mental retardation, illiteracy or speech and hearing difficulties were severe barriers to the success of rehabilitation and placement.

From the initial client evaluation, we were able to develop predictive indices of success with respect to employment. These indices included objective evidence of motivation.

Higher education and perception by the client that his/her health did not interfere with working as well as fitness and absence of gross obesity were associated with success. We found that female heads of household with a child under six in the home were likely to be successful in obtaining work or job training. If clients returned for a follow-up visit, this was also a good indicator of subsequent success in employment.

In our project we had two health facilities for AFDC clients, one inside and one outside the WIN system. Successful placement of our clients following rehabilitation and also of control clients, without rehabilitation, were substantially greater in the program outside the WIN system. We identified a low priority for the placement of clients with previous health problems by WIN/DOL.

It is therefore our conclusion that return of AFDC recipients to the labor force through health rehabilitation must depend both on the characteristics of the client group and on the demand for their skills or services in the job market. The standardized health evaluation, on a problem-oriented basis, which we propose would allow selection of a clientele for rehabilitation services whose problems would be likely to be remediable and who might be expected to be successful thereafter in employment.

Health units which could be introduced into WIN on a national basis should have two major components: that is, capacity for health evaluation and screening as well as a service component. Although we cannot at present override the client's right to health screening by their own MD, we do propose that if health evaluation is obtained from such a physician, that reporting should be on a problem-oriented medical record. Alternately we recommend that a nurse practitioner or MD be assigned by WIN contract to carry out health evaluations of WIN clients with health problems. Further we propose that WIN units employ a health counselor who should have skills in health education and counseling as well as a knowledge of locally available health and social support services. Job development, appropriate to the needs of clients who have had health problems, should also be given priority.

Our experience suggests that expenditures for health rehabilitation, which can fit clients for the work force, could be cost effective over allowing persons to remain on AFDC if their health problems are in fact remediated on a long-term basis. It is assumed that in the future when WIN introduces health units, that health care other than that provided by health counselors and the initial evaluation provided by a nurse practitioner or MD would be covered by Title XIX.

Before developing a demonstration model, we communicated with WIN regional directors who saw a need for uniform health evaluations of clients claiming health problems as a barrier to employment. They also responded favorably to the idea of the introduction of a health counselor or health educator into the WIN system. Administrators and WIN staff with whom we communicated were emphatic that the demonstration model for the WIN health unit be a component of the WIN system.

In our proposed demonstration model, we believe that the target population should be AFDC clients presenting at WIN/SAU with health problems as well as clients from the unassigned recipient pool and VR rejects. We would like to see priority given also to WIN volunteers with health problems if these are female heads of household with children under six in the home. Persons within this target group would be referred within WIN/SAU to a health counselor who would then send clients for a health evaluation either by their own MD or by the assigned nurse practitioner or MD described above. Following receipt of a report from the nurse practitioner or MD, a client conference would be held between the health counselor, the SAU counselor, the employment counselor as well as representatives from VR or SSI if the case suggested this need. Clients who are not found to have health problems affecting employability would then have to register for WIN in the regular manner. Those with remediable health problems would be put into the "special programs" category and in this situation would be made eligible both for health services and for special employment placement. Health services to be offered by the health counselor would include health education, counseling, medical referral and assistance in obtaining health support services. After rehabilitation and as clients are made fit for competitive employment, they would be expected to register for regular WIN.

It is our suggestion that several variants of this basic demonstration model should be put into operation such that differences in staffing could be compared between units. Staffing differences would include in one unit the addition of a health counselor/health educator only. In another unit, the appointment of a health counselor and the assignment of a nurse practitioner or an MD to do health evaluations and in a third unit, the health counselor would also be a nurse practitioner and would carry out both the evaluation and the counseling. She/he would then be assisted by a community health worker. It is assumed that the demonstration model would be set up in a region where WIN units offer several demographically similar groups so that comparison can be made of the demonstration model with the classical (present) system or if several different demonstration models are set up, then also between the different models and the classical system.

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My deepest thanks are offered to the staffs of the demonstration project during the feasibility study. These included Mrs. Muriel Dickey and Mrs. Sally Nation, both who carried out duties as project nurse, and Dr. Curtis Hanners, psychologist who developed counseling services.

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I. BACKGROUND

A. Highlights of previous studies of inter-relationships between ill-health, poverty and unemployment

It has been demonstrated that there are a wide range of health complaints that keep indigent people out of the work force. These include 1) symptoms that suggest an inability to perform or perform consistently and well in the employment situation, e.g. blackouts, dizziness, poor eyesight, hearing loss; 2) health problems that suggest an inability to cope with stresses of the work environment, e.g. nervousness, and breathlessness on exertion or heat intolerance associated with obesity; 3) complaints of frequent illness commonly associated with absenteeism, e.g. chronic bronchitis, cystitis, migraine, dermatitis; 4) medical conditions for which it is difficult to exclude some degree of disability, e.g. back pains, restricted mobility of some parts of the body, varicose veins, asthma.

While it is evident that these kinds of health complaints will mitigate against the employability of socially advantaged as well as socially disadvantaged groups, they are a particular deterrent to the employment of persons with limited job skills or education. Whether or not these health complaints are associated with objective physical or mental illness, they will have an adverse effect on job readiness, and will be predictors of failure in job interviews and in the actual work situation (1-3).

Levitan, et al. (4) emphasized that poor health is a handicap to employment. They have pointed out that disability or ill health is substantially higher in poverty areas than in other areas. In a New York City study, it was found that of the population 25 years and over, 10 percent of all men and 15 percent of all women in the poverty areas were not participating in the labor force because of health problems, as compared with 4 percent of the men and 9 percent of the women for the rest of the population (5).

Sick role behavior, which includes persistent complaints of health problems not associated with objective evidence of disease, as well as inappropriate emphasis on existent health problems, is one of the characteristics of social failure. For passive, dependent people, it is a means of explaining an unsatisfactory life style. Women in a dependent situation report more sickness than men because it is for them culturally acceptable. Women or men who place a high value on self-reliance are least likely to adopt a sick role. Unemployment is associated with sick role behavior in many persons, but conversely employment as well as successful marriage both decrease such behavior. Those who play a sick role are likely to engage in a) excessive self-medication, especially with pain-killers, sedatives and tranquilizers; and b) binge drinking, because they are also means of blocking out their real social problems (6,7).

Complaints of health problems are significantly more common in persons who are underemployed or unemployed, whether or not these are actually associated with physical handicaps (8).

Evidence strongly suggests that there is a need for health intervention services to overcome sick role behavior, health education, so that clients can understand relationships between their life style and their health problems, and for rehabilitation to overcome common medical disabilities. Such health care lies outside the presently available medical services used by ADC persons who are potential or actual WIN/CETA registrants.

Apart from sick role behavior, common medical problems are frequently associated with health complaints which are a deterrent to work performance. For example, obese people will complain of difficulty in performing physical tasks because of breathlessness on exertion, excessive tiredness, backaches, and swollen ankles. Excessive alcohol ingestion is associated with blackouts, headaches, nervousness and indigestion. Various kinds of self-destructive behavior including excessive use of sedatives and tranquilizers, faulty diets, heavy smoking, factitial dermatitis and laxative abuse are associated with the symptoms and signs of disease. Neglect of medical problems including dental neglect through inadequate utilization of existent medical services or non-availability of such services contribute to the incidence of chronic disabilities in low income group populations which we have studied.

Persons with social disadvantages and health problems encounter barriers to job training and employment. Health barriers to employment appear to be greater for women than for men. In both sexes, handicaps associated with health problems can only be effectively treated if optimal health care is provided. Barriers to the utilization of effective medical treatment by individuals in low socioeconomic groups exist. Bergner and Yerby (9) have noted that the relatively low utilization of health care facilities by low income families is not due to fewer health problems. According to these authors,

> "an elaborate array of services of the highest quality is not truly available if those who are most in need are unaware of their existence and availability. Although we are most anxious and concerned with the health problems of the poor, we know that these problems are so intertwined with social and welfare problems that provision of accurate information in one area...is likely to be meaningless and can actually serve to reinforce feelings of frustration and resignation to the status quo. Broad-purpose neighborhood information and service centers may be a means of attacking these problems of communication. We need to search out and reach out to these people. They can be reached if the effort is made. The use of community health aides is one approach to this problem...Unfortunately...the expensive Medicaid program does nothing to insure that comprehensive care

> becomes the standard care. The custom of episodic care and the separation of preventive and therapeutic medicine are maintained...The patients' needs, expectations and priorities are not allowed to interfere with the functioning of the system." (9)

Although physical rehabilitation has been extensively used as a means of treating severe disability and overcoming physical handicaps in severely disabled persons so that they can obtain employment, it has not been widely extended to the management of disabilities associated with chronic but moderate health problems. Adequate management of obesity, treatment of musculoskeletal problems, treatment of correctible vision and hearing defects, dental therapy, treatment of chronic dermatoses, and counseling for neuroses and sick role behavior have rarely been undertaken as a primary means of returning men and women to the labor force. It is commonly believed that restorative treatment for these and related health problems is not feasible for low income persons; reasons being cited include cost, lack of personnel, transportation difficulties, particularly in rural areas, lack of child care, lack of motivation on the part of the subjects, and lack of community interest. Yet, lack of rehabilitation for the above-mentioned and related remediable health problems lies in contrast to the fact that employers will frequently exclude job applicants with these kinds of handicaps.

A most important determinant of success in health rehabilitation for work is job placement. Not only as an end result of rehabilitation but as an integral part of the rehabilitation process. Commenting on the successful vocational rehabilitation of persons who have had mental illnesses, Rubin and Roessler (10) state "in conclusion, one of the most important treatment outcomes for the psychiatrically disabled is the acquisition of employment...Vocational rehabilitation services play a significant role in the treatment. Comprehensive evaluation of client's strengths and weaknesses enables the counselor to help the client select appropriate vocational objectives during planned development. Often that plan will require training in work adjustment and in job seeking skills to ready the client for vocational training and/or placement. Breakdowns in any of these steps significantly increase the probability of unemployment..."

It has been the experience of a director of an occupational health services department in a division of personnel in California that it may be desirable to allow obese persons to enter employment on the condition that during a probationary period, they would comply with a requirement for weight reduction. A significant number of these persons have returned at lower qualifying weights and have maintained their lower weights for extended periods of time, apparently as a result of the conditional nature of their employment (personal communication).

In 1978, report by Morehouse (11) on the treatment of alcoholics on Public Assistance, the following comments are made and conclusions reached: "When the alcoholic on Public Assistance stops drinking, he often finds that he no longer enjoys spending the day with drinking acquaintances. As a result, there is a feeling of boredom and restlessness that is frequently expressed by the alcoholic's sudden desire to seek employment, further education, or job training. It is necessary for the therapist helping the alcoholic understand that he will need a few weeks to adjust to being sober before these avenues can be explored. Return to work or school should not be recommended until there is a complete evaluation of the alcoholic...Too often premature entry into work or school leads to the alcoholic's inability to meet the demands of the situation and increases his feelings of failure, and drinking results. A day treatment program, a part-time job, or part-time school attendance can be effective in helping the alcoholic get used to a routine and to feel he is working towards something."

The Manpower Report of the President, transmitted to the Congress, April, 1975, included discussion of the WIN program as well as other manpower programs. From that Report, the following is pertinent to this project report:

> "Beginning in 1962, Congress funded Community Work and Training projects, which provided jobs in public and private non-profit settings to enhance the employability of public assistance recipients and to allow them to "work off" the cash value of welfare payments. In 1964, the Economic Opportunity Act (EOA) expanded the funding for this program, called it Work Experience and Training, and broadened the categories of eligible recipients. The problematical history of these programs encouraged another redesign in 1967, followed by the establishment of the Work Incentive (WIN) Program in 1968. At the beginning of 1972, subsidies (in the form of tax credits) were offered to private employers who hired people through WIN and kept them on the job for at least a year; and in mid-1972, when WIN began to place more emphasis on placements, a public employment component was added to enlarge the number of job openings.
>
> The results of these programs have not matched early expectations. First, only a minority of welfare recipients (about one-third of 1973 registrants) can be considered fully employable, since most have work disabilities, child-care responsibilities, and other handicaps. Among those who can work, the most qualified often find their way back into the labor force on their own." (12)

Table 1 Characteristics of enrollees in the Work Incentive Program (WIN) for fiscal year 1974. [a]

Category	Percent of total enrollees
Sex	
Women	72
Men	28
Ethnic origin	
White	45
Black	42
Spanish speaking	13
Age	
under 22 years	12
23-44 years	77
45 years and over	11
Years of school completed	
under 8 years	12
8 - 11 years	77
12 years and over	11
On Public Assistance	100

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[a] Adapted from Table 4. Manpower Report of the President, April, 1975, p. 115.

In their analysis of the cost estimate for H.R. 7200 "Public Assistance Amendments of 1977" to the U.S. Senate Committee on Finance, the Congressional Budget Office directed by Alice M. Rivlin made the following statements about the WIN program:

> "This provision [Section 520. Implementation of work and training requirements under aid to families with dependent children programs.] would essentially extend the WIN requirement of AFDC eligibility to include a continuing job search for those not specifically exempted. ...... Savings due to this provision would occur if people are placed in jobs through the WIN program and as a result have lower AFDC payments. The problem is that WIN programs do not appear to affect employment greatly.
>
> Although about one-third of those receiving WIN services do find employment, this apparent success cannot necessarily be attributed to WIN. That, those who do improve their employment situation seem to be those who would do so on their own in the absence of WIN. Studies that have matched WIN participants with control groups not receiving WIN services find either no effect or only a small net effect from the WIN program. (And even in studies which show a small effect due to the WIN program, the subsequent reduction in AFDC costs was not sufficient to offset the cost of WIN.)" (13)

A summary of the PR/A Research Report on WIN unassigned recipients, prepared by Art Evers of the national WIN office shows 59.97 percent of the WIN population in the study to be in the unassigned recipient "pool". Thirty-six percent of the unassigned recipient group were found to have medical problems. However, only one-third of these appeared incapable of assuming full-time employment. The summary further states:

> "Accurate medical assessments of how the medical problem of the client effects job readiness and information on whether the question of supportive services was addressed is not contained in the clients' file. A high proportion of site active females (27%) and site inactive males (26%) and females (40%) have some medical problems. Most prevalent are hypertension, bronchitis, back problems, and nervous conditions. If the client has multiple problems he/she is placed in VR status and receives no further assessment. Some states make the client temporarily exempt and give the client 30 days in which to obtain medical substantiation. In some sites, where colocation was not effective, lack of cooperation between welfare and WIN affected the assignment of exempt status. Colocation units have more efficient medical and certification procedures." (14)

B. Previous studies by the Principal Investigator of health and unemployment

In a health and nutrition survey conducted by the Principal Investigator over the years 1971-1973 (15), the sample population consisted in 469 female welfare and ex-welfare recipients resident in rural areas and small towns in Upstate New York. It was found that the greater the total number of current medical complaints that the women reported, the less likely they were to be employed. Among these complaints were nervous symptoms including tiredness, insomnia, headaches and other neurasthenic symptoms which together were significantly more common in the non-working groups. Physical and mental disabilities, documented by examination, were also associated with unemployment. Most medical findings were of chronic ailments which could have been prevented. Included in this category were obesity and its complications, late effects of accidents, infections or nutritional deprivation, back syndromes, as well as a variety of chronic cardiovascular and respiratory diseases. Obesity was the most common nutritional problem encountered. Unemployment was related to obesity, and the incidence of unemployment was directly associated with the degree of fatness. The association between unemployment and obesity could be explained as being due to the co-existence of diseases known to be complications of obesity, such as hypertensive heart disease and diabetes. Women with job skills were less likely to consider their health problems limited the type of employment they could undertake. A large subgroup of the population had not availed themselves of preventive health facilities or care. A small group had apparently never been to the doctor even when sick. Cultural fear of doctors and dentists was found. Examination of Medicaid records showed that symptomatic care took undue precedence over preventive medicine, and that prescription drugs were consumed excessively by the population. Employers of the sample recognized certain health problems as occupational or insurance risks. They were, therefore, as reluctant to hire women with obesity, back problems and skin diseases as they were to take on those with gross physical defects or severe alcoholism.

In a feasibility study on the effects of health intervention on employability conducted by the Principal Investigator in Ithaca, New York from December, 1974 to May, 1975 (16), sick role behavior was identified by the number of current symptoms and a hypochondriasis index. The number of current symptoms showed a negative correlation to the percent of time that the client had worked since the age of 18 ($r = -.25$, $p < .04$). The hypochondriasis score was also negatively correlated with this variable ($r = -.30$, $p < .02$). Identification of sick role behavior requires not only the utilization of such a scoring system, but also a complete physical examination and medical workup to insure that the health complaints are not associated with medical or other disease. This requires the services of trained health personnel. Poor work histories and prolonged unemployment were significantly associated with the total number of health complaints by the clients. Many WIN or CETA staff persons can be misled in taking the client at his/her word, especially if the client can demonstrate or enunciate a good case for exemption from registration before health evaluation has been carried out. Registrants, professing "sick role behavior", may be put into an unassigned recipient pool when, in fact, they should be active in training or job placement. Many medical practitioners who are unused to evaluation of sick role behavior will accept their patients' complaints and offer palliative treatment rather than intervention. People who play a sick role are sick and are not malingerers, since they do not possess insight into the nature of their problems. Sick role behavior can be treated by group counseling techniques. Decrease in the hypochondriasis score -- a measure of sick role behavior -- was correlated with the number of group therapy sessions attended (Spearman's $r = .32$, $p < .01$). In group counseling sessions, specific health problems raised by the client can be handled without necessity for analytical techniques. Paraprofessionals can be involved with a nurse practitioner or health counselor supervising the sessions.

In our feasibility study of health problems in an ADC population, it is to be noted that the most common handicaps found were aversive (obesity and dental decay) as well as emotional (depressive neuroses and sick role behavior). A significant rank correlation was found between aversive handicap and age ($r = .32$, $p < .01$). Maximal pay category in previous jobs was inversely related to the presence of aversive handicap ($r = -.25$, $p < .04$) and to the number of initial medical problems ($r = -.24$, $p < .06$ ns).

We identified several components of health intervention which can contribute to job readiness. These include complete medical evaluation and description of the required rehabilitation period. Group counseling, emphasizing motivatior, should be available to those exhibiting sick role behavior or such other disorders as depressive neuroses. Supportive individual counseling is required for specific personality disorders, episodic drinking, etc. Health education is needed, not only to acquaint them with and promote their use of area health services. There is a need to emphasize through structured teaching, compliance with the remedial health programs, including meeting a contractual arrangement. The director and professional staff need to be advocates for the health care of any individual client with respect to referrals to area physicians, dentists, clinics, laboratories and other ancillary health services that are required.

Factors which we found to be associated with inadequate utilization of health care include ignorance of the existence of the facilities, negative health attitudes, non-compliance with treatment, reliance on emergency room care, and dependence on health advice and treatment from subprofessionals. Further, persons adopting a sick role seek out only such health advice and treatment which will maintain them in their status quo.

In our feasibility study, we demonstrated that it was possible to establish a health evaluation and rehabilitation unit designed to meet the needs of an ADC population whose health problems have retarded their employability. Common remediable health problems which were encountered among those participants included obesity, hypertension, musculoskeletal defects, visual impairments, deafness, dental decay, neuroses, personality disorders, and complaints associated with sick role behavior. Successful outcome of health rehabilitation was associated with effective treatment of presenting health problems, management of disabilities, both physical and mental, and reduction in sick role behavior. Effective rehabilitation was significantly related to the level of clients' participation in in-house programs such as those designed for weight reduction or to overcome neuroses and sick role attitudes. The number of contacts or communications between the rehabilitation team and the clients was not significantly associated with successful outcome of rehabilitation. Factors mitigating against success included welfare institutionalization and the presence of severe personality disorders. It was clearly identified that once clients had a complete medical evaluation and were also acquainted with in-house and referral services provided by the project, the first stage of intervention had been reached. In other words, in order to separate the intervention from non-intervention groups, it was necessary to confine contacts with clients initially to health evaluation; services relating to rehabilitation should not be offered at that time.

We are aware that compliance with a prescribed treatment plan has not been adequately emphasized when rehabilitation has been initiated. Although Frances, et al.(17) have demonstrated that there may be a significant relation between patient satisfaction with services and compliance, this has not been our experience. In our experience, lack of compliance was associated with welfare institutionalization, lack of a "Protestant work ethic", disorganized households, and more especially, lack of motivation to acquire good health. Group counseling can increase motivation for health improvement and for the desirability for economic independence. It became evident that such counseling should be given concurrently with health education, in which the objectives of therapy and, more especially, the need for compliance are clearly explained.

During the feasibility study it was found that treatment protocols were not always followed rigorously by the professional staff. However, as demonstrated by Grim, et al.(18), patient-care protocols provide an effective means of monitoring the process of medical care.

Conclusions concerning the feasibility study are summarized in a report transmitted to USDOL, Washington, June 3, 1975, in which it was pointed out "that the most successful aspects of the program had been the development of inter-agency relationships, multiphasic screening procedures, a mental health counseling program, referral services and a job motivation program as well as the nonthreatening supportive role of the staff". The project had provided a viable community resource for the screening of welfare dependent persons eligible for CETA registration and presenting with health problems which were believed to interfere with their ability to enter job training or the work force. Remedial health measures were found to be feasible for a large number of these persons whether their disabilities were objective or related to the development of the sick role. Health intervention was seen to need to be coupled with job motivation and it was found that this was possible under the program.

II. FIELD STUDY

A. Aims

The primary objective of the demonstration project proposed by the Principal Investigator was to develop a model on which to base regional health evaluation and intervention program appropriate to the needs of the WIN program. Data generated were also to be used in defining policies affecting the use of medical exemptions from the WIN work registration requirement and the use of medical criteria in defining the employability of WIN registrants. Dependent upon these overall aims, the project was established:

1. to define health-related handicaps of potential WIN/CETA registrants and to distinguish sick role behavior.
2. to examine the feasibility of providing medical care with job development and placement services, to select groups of ADC recipients who were not working because of health problems, real or perceived.
3. to determine to what extent ADC recipients with health-related work disabilities could be returned to the labor market through physical rehabilitation: the hypothesis being that health disabilities needed to be corrected before a job could be held successfully.
4. to prove whether or not expenditures for health rehabilitation, facilitating employability, could be a cost-benefit over allowing ADC recipients with health problems to remain outside the work force or to take care of their own health problems.
5. to determine whether health rehabilitation for remediable disorders is an appropriate function of the WIN/CETA programs and its general applicability to projected Manpower programs.
6. to determine whether such a health rehabilitation program should be incorporated into regional or national health care policies.

A modification of aims introduced by WIN USDOL was accepted as follows:

1. development of a model rehabilitation and placement program suitable for national implementation throughout the WIN program;
2. conduct of a rehabilitation and placement program that will return to the labor market AFDC recipients with health-related work disabilities;
3. assess the outcomes of the project in a way that will determine whether expenditures for health rehabilitation that facilitates employability is cost beneficial over allowing AFDC recipients to remain outside the work force;
4. recommend the kinds of disabilities that are suitable for treatment within a national program; and,
5. measures the outcomes of the project in terms of placements, job tenure, and administrative feasibility.

B. Structure

1) Program development

The active phase of the demonstration project began in November, 1975, a month following receipt of the grant award. At this time, preparations were made for the development of a CHRP project in Syracuse, New York and the revision of the pre-existent CHRP program in Ithaca, New York.

a) WIN - Syracuse

Project development in Syracuse included the acquisition of a facility, staffing of the facility, development of liaison with area agency staffs, establishment of procedure and dissemination of information with respect to the purposes of the Cornell Health Rehabilitation Project. A most important element of this development phase was the education of the Principal Investigator with respect to the WIN procedure and practice. In November, 1975, a search was made for a facility in Syracuse. Because of a then current idea that it would be appropriate to establish a CHRP site in an area of residence of the expected AFDC client population preference was given to a facility in a low-income area. Due to this rationale and also the offer of a mutually agreeable rental arrangement, CHRP was located in Syracuse at the Syracuse Model Neighborhood Facility. Staffing of this CHRP facility required the selection and appointment of a physician and two other staff members who would work only in CHRP, Syracuse. A rehabilitation counselor was also appointed with duties partitioned between Syracuse and Ithaca. Publicity on CHRP was achieved via the news media including the local newspaper and radio station.

Meetings were held with administrators of the Department of Social Services and the New York State Employment Service. Current procedures with respect to nonexempt and exempt AFDC WIN registrants were described and plans made for integration of CHRP into the existent system. It was explained that DSS/SAU and DOL elements of the WIN program in Syracuse were collocated and that AFDC clients were referred for interviews first with WIN employment services staff followed by interviews with SAU staff. A joint conference was then held to decide whether or not medical evaluation or assistance was required for potential WIN registrants. The decision as to whether or not to proceed with registration was made at that time. Clients claiming medical disabilities were referred to VR who then made evaluations and reported whether they would accept a client in which case that person would become exempt from WIN registration. In 1975, 200 referrals were made to VR with 60 not accepted because their health problems were not considered to be severe enough to be considered handicaps of a permanent nature. Clients who were not accepted by VR were then returned to DSS for further evaluation, but registration under WIN was delayed. Under the new arrangements with the CHRP program, clients considered to have health problems at the time of their interviews with the WIN sponsor and SAU staff would be referred to CHRP if a decision was made that they were not appropriate for VR. In addition, those clients who had been referred to VR and had been refused VR services would also be sent to CHRP if the client wished to avail him/herself of these services. Information on CHRP was to be given to clients in these categories and further action would then depend on the client volunteering to accept referral to CHRP. If referral to CHRP occurred, clients were to be deregistered from WIN.[*] An understanding was reached that nonexempt clients who were referred to CHRP and who subsequently on health evaluation were found to have no health problems which would interfere with their ability to enter job training or accept employment would forthwith be referred back to the WIN sponsor for registration.

It was agreed that all clients referred to the CHRP facility would be given a comprehensive health evaluation and that of those who were found at that time to have a remediable health problem 50 percent would be randomly selected for active health intervention. When in the judgment of the professional CHRP staff a client in active health intervention was considered ready to enter job training employment, he/she would be referred back to the WIN/SAU office for registration. During the process of health evaluation and intervention, reports were to be sent at thirty-day intervals to the WIN sponsor to describe the client's compliance with prescribed treatment as well as the client's progress. It was agreed that health intervention should not generally exceed six months. Clients who were to be evaluated by CHRP but who then were not in the active intervention component would be referred back to WIN/SAU and directed by that agency to an appropriate health care system. When child care, meals or transportation were required for clients in CHRP, these were to be provided by the project itself and not by the WIN porgram. A caseworker with special experience in rehabilitation counseling was given responsibility for referral of AFDC clients to CHRP and for keeping records of their progress and accepting them back when health intervention had been completed. All initial health evaluations were to be reported to this caseworker on forms indicating the client's complaint, health findings, existing handicaps and the intervention deemed necessary, including the time component. By communication between the professional staff of CHRP and WIN/SAU, clients might be registered for WIN prior to the completion of health intervention if it was mutually agreed that adequate progress had been accomplished. This measure was adopted to avoid delays in client's entering available OJT slots or classroom training situations. An arrangement was made for emancipated minors, ages 16 to 18, who were out of school and on AFDC and mandatory for WIN to be referred to the CHRP program under the system described above.

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[*] At a meeting with county and regional DSS, employment service and WIN personnel on December 19, 1976, CHRP staff obtained clarification of WIN/SES requirements as they applied to persons referred from CHRP. WIN/SES was to implement the policy of 1. no deregistration except by CHRP request or 2. no deregistration unless WIN/SES saw the necessity to deregister for nonhealth reasons. In a phone call from WIN/SAU on March 23, 1977, it was reported that 60 percent of the CHRP rehabs had been reregistered with WIN.

b) CETA - Syracuse

Meetings were held with administrators of both the Onondaga County CETA program (OCETA) and Syracuse City CETA program (SETA). It was arranged with these persons that clients who were potential or actual registrants for the CETA program and at the same time receiving AFDC assistance would be referred to CHRP for health evaluation and possible intervention if they claimed health problems which might exempt them from registration. AFDC clients, registering for OCETA or SETA might come from DSS or by self-referral or by alternate agency referral. If a medical disability was claimed by an OCETA eligible AFDC client, referral to VR was limited by prior screening. Referral of clients both from the OCETA and from the SETA agencies would be after individual caseworkers had been assigned. When health evaluation had been carried out by the CHRP staff, then reports identical with those going to the WIN staff would be sent to the caseworkers of the referring CETA agency. The agency would also be notified as to whether the client was to be accepted for health intervention. If health intervention was to be carried out, a thirty-day progress report would be sent to the CETA agency and at the time that the client was ready for job training or employment he/she would be referred back to the CETA agency for registration. Notification of noncompliance or nonattendance at treatment sessions would also be sent to the responsible agency.

Administrators of WIN/SAU, OCETA and SETA gave us written assurance of their full cooperation in client referral, as well as their commitment to supply CHRP with reports on client's progress with respect to job training and employment.

c) Ithaca

Meetings were held with administrators and staffs of the Department of Social Services, the New York State Employment Service and CETA. It was decided that clients on AFDC, considered to have health problems would be referred from DSS to the CHRP unit in Ithaca. Health evaluations would be carried out and decisions would be made as to whether health problems were present which were amenable to health intervention. From this pool of persons with remediable health problems 50 percent would be randomly chosen for active health intervention by CHRP. Reports on health evaluations would be sent to DSS. Progress reports would also be sent at thirty-day intervals on those clients receiving health intervention. Clients who had successfully completed health intervention would be referred back to DSS. Clients who had health evaluations but were not accepted into the program through random selection would be sent back to the referral agency with recommendations that the case worker discuss health problems discovered and treatment recommended.

d) Medicaid - Syracuse

All clients accepted into the CHRP program or receiving health evaluations were by definition on Medicaid. Meetings were held in Syracuse with Administrators in the Onondaga County Health Department. It was indicated that all referrals, which were recommended by CHRP during evaluation or rehabilitation and which would incur costs, would be covered by Medicaid provided that prior approval was obtained. In order to limit Medicaid costs, CHRP would also receive reports of recent Medicaid services that had been afforded to clients so that duplication would not occur. By mutual agreement decision was made to utilize various health care delivery systems within Onondaga County and the City of Syracuse which were approved by the Public Health Department of the city and county and to diversify referrals such that no one health care delivery system was overutilized. Reports of Medicaid costs were to be given to CHRP through their computerized accounting system. It was also agreed that CHRP could call upon the public health nursing service when necessary and where it was imperative that access be gained to clients' homes.

e) Medicaid - Ithaca

In Ithaca and Tompkins County similar arrangements were developed with the Medicaid authority and with the Tompkins County Health Department.

2) Staff

a) Syracuse

Four staff members were engaged in the Syracuse unit: a physician, a nurse/health counselor, an office manager, and a rehabilitation counselor. The physician from the family medicine clinic was appointed to oversee the CHRP medical services and to carry out health evaluations and direct in-house health intervention. He agreed also to undertake referral of clients accepted into the program and to make appropriate and regular reports to the WIN and CETA authorities. His past experience had been in large scale health screening and also in working with disadvantaged clients. The nurse, who had had LPN training under CETA and a registration obtained in the UK as a mental health nurse accepted the position as nurse and health counselor in the Syracuse unit. The office manager had had training as a health aide, recently working on the Onondaga Indian Reservation. She also had secretarial skills and office experience so that she could keep records and perform stenographic services within the Syracuse facility. The rehabilitation counselor (MS degree in rehabilitation counseling) with professional certification was engaged as a psychiatric social worker for both the Syracuse and the Ithaca units. Her experience had been in working with area units in drug rehabilitation.

b) Ithaca

The staff of the Ithaca unit included the Project Director, the project coordinator for both the Ithaca and Syracuse projects, a nurse, and an office manager. The Project Director, who in addition to overseeing the total program accepted the responsibility for health evaluations and decisions on client disposition. The project coordinator with formal qualifications as a medical records librarian and extensive experience in a number of community projects initiated and promoted agency liaison. In Syracuse, she arranged for client referrals to CHRP and back to the WIN and CETA agencies. In Ithaca, she also acted as education advisor, job counselor, liaison with the employment service, and advocate in nonhealth-related client problems. The project nurse was qualified as an RN and had had special experience in working with low-income families. The office manager had both stenographic and other office skills and had training as an LPN and had worked as a supervisory nutrition aide for Cooperative Extension in Tompkins County. As the project developed, she accepted further responsibility in the development and supervision of in-house health intervention programs.

In terms of the mandate of the project, it is important to note that three of the staff members between the units had had their training under federal (CETA, USDA-EFNEP) programs.

3) Facilities

a) Syracuse

The Syracuse CHRP facility was established within the Syracuse Model Neighborhood Facility, a multi-purpose unit providing health and recreational services to a low-income area. A ground floor office and counseling room in this facility were rented and furnished, rental being paid from project funds. In addition, two rooms including a medical office and an examination room were obtained for use on a part-time basis in a section of the facility rented by the Onondaga Health Department. Use of a waiting room area for clients adjacent to these offices was supplied under the agreement with the facility. In summary, it was agreed that on a full-time basis an office and a counseling room be provided by the facility and on a part-time basis the remaining space. Utilities were provided and also furnishings. Movable equipment necessary to the medical program of CHRP was provided by the project.

b) Ithaca

In Ithaca, the facility which had been used during the feasibility project at the Cooperative Extension Building was renovated in order to facilitate the program and more particularly to provide separate counseling and consulting rooms. This facility, in a low-income area, was well placed with respect to the clients to be served.

4) Sample groups - theoretical design of the study

In the project proposal, the sample group was to consist of approximately 300 men and women between the ages of 18 and 50 years on AFDC. Persons having these demographic characteristics and considered to have health problems which interfered with their ability to work were to receive health evaluation. Health determination was to consist in documentation of medical history and health complaints, a physical and psychological examination and ancillary testing procedures including laboratory and radiological tests of health status. In the evaluation, indices of intellectual capacity, hypochondriasis and motivation were to be obtained. Clients having nonremediable health problems were to be excluded from further participation and referred to DSS for placement in appropriate health agencies or vocational rehabilitation units. Those having no health problems were to be referred back to WIN/CETA authorities and to be followed up insofar as information could be obtained from these authorities with respect to the outcomes of these persons in relation to job training, job placement, welfare status and financial status. Clients found to have remediable health problems were to be randomly assigned to intervention and nonintervention groups using tables of random numbers such as to include 50 percent of the sample in each group.

A summary of health problems existing in persons within the nonintervention group (nonactive intervention) would be given to clients and also sent to the referring agencies. These clients were told how they could obtain health care needed and then could then either seek care on their own initiative or might be assisted in obtaining health care through the assistance of responsible caseworkers. Family physicians were also to be sent reports of the health evaluations of these persons. Those in this nonintervention group with health problems existing at the time of evaluation would be followed up by the professional staff of the demonstration project at three-month intervals thereafter until nine months had been completed or until the completion of the study.

Those in the active health intervention groups would be offered in-house rehabilitation programs appropriate to their single or multiple disabilities including group counseling, individual counseling, weight reduction, health education and specific instruction on compliance with the prescribed therapy. The project director as well as the professional staff in the project facilities were also to act as advocates for these persons in referral to health clinics, physical rehabilitation programs and family planning clinics. Active intervention with respect to these groups might continue for a minimum of three months and a maximum of six months. In any case, progress in rehabilitation was to be fully evaluated in three months and the desirability of continuing the rehabilitation assessed at this time. At the completion of the rehabilitation phase, clients in the intervention group would be followed up in the same manner as the nonintervention group with health problems.

In the actual program the demographic characteristics of the sample differed from the theoretical model through the inclusion of home relief clients and through the separation of specific intervention groups not foreseen at the time when the project proposal was submitted. In Ithaca, a special control group was also obtained outside the sample. This group consisted in men and women who were not on public assistance but were applying for county employment. This group was utilized for pretest purposes.

Final intervention groups in Ithaca and in Syracuse were as follows:

1. Intervention active) both of these groups had
2. Control) remediable health problems.
3. No health problems
4. Nonremediable health problems
5. Client refused to participate in the CHRP program
6. CHRP refused inclusion of client for other reasons, including persons already receiving adequate health care.

C. Process

1) Mode and reason for client referral to the program

a) Syracuse

Major source of client referral in Syracuse was via WIN/SAU. These clients by definition were in receipt of AFDC. Minor sources of referral of clients in Syracuse included Income Maintenance, including clients on Home Relief, WIN/DOL, OCETA and SETA.

b) Ithaca

CHRP was utilized by DSS primarily through the supervisor of the Income Maintenance unit. The discovery of clients having health problems appropriately to be referred to CHRP was made at the caseworker level. Clients referred included those on AFDC and Home Relief. Other sources of indirect client referral in Ithaca included New York State Employment Service as well as the local alcoholism and drug abuse unit. When clients were referred from these sources, notification was made to DSS and approval obtained before client evaluation was initiated.

2) Health evaluation

Questionnaires used in the program for health evaluation were revised as an outcome of the feasibility study. These questionnaires were pretested on 46 persons who were referred to the Ithaca unit at the project director's request for physical examination. These persons were ineligible to enter the program since they were not in receipt of public assistance. On each client, case records were obtained for each of the following categories (see Appendix):

1. agency contacts
2. work history
3. medical history
4. physical examination
5. anthropometric data
6. health attitudes and awareness questionnaire
7. drinking and smoking questionnaire
8. food frequency interview
9. life setting inventory
10. prior utilization of health services
11. psychological problems evaluation checklist
12. psychometric testing

The project paraprofessional staff in the two units administered the questionnaires and completed forms other than those pertaining to the medical history, physical examination and mental health evaluation. The medical history and physical examination were obtained by the respective unit physicians. Mental health evaluation was carried out by the psychiatric social worker and consisted in the administration and evaluation of psychometric tests and a personal interview. Routine laboratory tests carried out on clients included complete blood count, a biochemical profile and urine analysis. These laboratory procedures were carried out in Ithaca in the pathology laboratory of the Tompkins County Hospital and in Syracuse mainly at the laboratory at St. Joseph's Hospital though the laboratory of the Neighborhood Health Center was also utilized.

At the completion of a health evaluation which, including the mental health evaluation, lasted for about 3 hours, not inclusive of the time required for the interpretation of information obtained, a case evaluation was undertaken by the physician in collaboration with the unit staffs. Positive health findings were enumerated in order of their importance in affecting employability. In the circumstance that further evaluation of a specific health problem was required before diagnosis could be made, a client might be referred for specialist evaluation by an area internist, surgeon, dentist or other health professional having special expertise and diagnostic skills pertaining to the health problem. Such referral was not a part of health intervention but part of the initial health evaluation based on the initial diagnoses and the overall evaluation of the client.

Intrinsic handicaps were identified using the Agerholm classification (19). This classification identifies health disabilities by type and is appropriately used for examination of work handicaps. Refinement which was used in our program was to identify whether or not the disability was severe or moderate. These intrinsic health handicap categories are: 1) locomotor, 2) visual, 3) communication, 4) visceral, 5) intellectual, 6) emotional, 7) invisible and 8) aversive handicaps.

Nonhealth handicaps (extrinsic handicaps) were also identified and recorded. The extrinsic handicaps included: 1) family, 2) educational and job skills, 3) housing and transportation and 4) problem or inadequate relationship with other societal groups or individuals.

Psychometric testing included the following: the MMPI Hypochondriasis scale using the questionnaire and scoring system from the MMPI Handbook (20), the Rotter internal-external scale which determines predominance of internal motivation vs. passive dependency (21), the 16 PF (Personality Factors) outstanding themes, as a measure of personality traits (22) and the Revised Beta Examination (23) as a measure of intelligence for the major portion of the clients in the study and the Wechsler Adult Intelligence Scale used in the beginning of the study (24).

When the health evaluation was complete, a case conference was held at which time the disposition of each client was decided. For all of those who were believed to have remediable handicaps, the health intervention indicated was recorded on the health evaluation forms. This group was then randomly assigned to the active intervention group or the control group. Other groups defined at this time were clients with no health problem and those having nonremediable health problems. In addition to the latter group, there were clients who were not believed to be appropriately in the CHRP program because they were already receiving adequate health care or they planned to move from the area.

When disposition of each client had been decided, a case conference with the client was set up. At this time clients were acquainted with their health findings and the advised health care if such was required. Clients who had been randomly selected for health intervention were invited to participate in the CHRP program after the indicated intervention had been explained. Control group clients were acquainted with the nature of the medical findings and were given appointments for follow-up. They were also told precisely what health intervention or advice was necessary in order for them to become fit for work. At this client interview, clients having been informed of the CHRP program and the specific intervention suggested to them could refuse to participate. Such persons could be either in the active intervention or in the control category, the latter refusing because of a lack of desire for follow-up. Participants were asked to sign a release of their medical and other records at that time.

3) Reporting system

Reporting forms were developed for use within the CHRP system. Forms recording findings on the initial health evaluation were of two kinds. Form A, which gave the referring agency a comprehensive listing of medical findings affecting employability, work limitations and the proposed client and/or health intervention referral was used in the Ithaca unit for all clients and in Syracuse for clients whose evaluation had been completed. In Syracuse where health screening of clients was carried out to determine initially whether or not they had remediable health problems, Form B was used as an alternate to Form A. Form B was also used when a client who had been referred was found either not to have any health problems or to have health problems which made him/her inappropriate to the program. Form B was approved by WIN/SAU-Syracuse because it could be completed after one health evaluation session and could be returned to the referring agency within 48 hours after that examination had been made. Form A was returned within approximately two weeks depending on the status of medical reports from physicians (or clinics or hospitals) and also in those instances where clients required outside medical referral in order that his/her health status could be more fully evaluated. (Forms appear in Appendix)

A separate reporting form, Form C, was used in order to transmit to the referring agency reports on client progress. Form D was used to indicate termination of client participation in CHRP. It indicated as did the other forms the intervention category of the client, whether or not the client had completed the prescribed health rehabilitation program, his/her employability and whether there were any residual health problems or handicaps present. In Syracuse, case termination with transmittal of Form D to WIN/DSS implied referral of the client back to that agency. In Ithaca, where continuous phone contact was maintained with DSS and NYSES, client progress and job readiness did not require transmittal of Form D.

4) Health intervention

a) Client conference and contractual arrangements.

For the active intervention group, post-evaluation interviews were held following acceptance of clients into the program. At these sessions the treatment plan was described in detail to the client and its completion related to a time frame. Each client within this group was given full information on the number of treatment sessions that would be required, the number of medical referrals and approximate duration of each therapeutic session. Explanation was given at that time that successful completion of health rehabilitation would require that the client be returned to the referring agency and hence to the employment service. For clients participating in in-house health programs, goals for each session were explained to the client verbally and in writing. Required compliance of clients with the prescribed therapeutic sessions was emphasized as a requirement for success and the client was asked to read and sign a contract of intention to cooperate. It was also conveyed to each client that CHRP would act as an advocate for the client in the health care delivery system and would assist the client in obtaining total medical care necessary to their condition. The clients were therefore made to realize the active responsibility of the CHRP staff as well as their own responsibility as a participant in the program.*

b) In-house programs

Health programs were developed within the Ithaca and Syracuse units to educate clients to improve their physical health and also to assist individuals to overcome emotional problems expressed as anxiety-depression or sick role behavior. These aims of the in-house programs were developed because the feasibility study had shown that the health problems which were most likely to keep clients out of the work force were signs of personal neglect, lack of physical fitness, substance abuse, preoccupation with ill health or psychosomatic disease. Extrinsic handicaps were addressed insofar as these were related to health or employability. It was the intent of the CHRP's Director and staffs to make the clients aware of their own health needs, to offer positive and practical advice on hygiene, diet, alcohol and drug intake as well as to encourage physical activity. Counseling was provided both by the rehabilitation counselor and the rehabilitation staff to promote self esteem and to address those emotional problems which would mitigate against successful employment.

Three programs were instituted, viz: health education, weight reduction and mental health counseling. Each of these programs stressed the involvement of the client in the decision-making process with respect to health and vocational goals.

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*The mean number of days between the initial client examination and client conference to discuss case disposition was thirty days for intervention clients and thirty-two for control clients.

i) Health education

The health education program ran for approximately 4 weeks with bi-weekly classes. Questionnaires pertaining to instructional material were given out each second week. Classes consisted of lectures, tapes, role play, films and practical demonstrations.

1. First session on hygiene, including bathing, personal grooming and care of clothing.
2. Second session on food buying and food budget. Included were food groups, diet diversity, how and when and where to buy different foods; also food storage and use of food stamps.
3. Third session: a. self-medication; and b. compliance with prescribed treatments. Included was information on how to deal with current health problems and their symptoms. Abuse of analgesics and other over-the-counter medications was discussed. Relationships between inadequate effects of treatment and non-compliance was described.
4. Fourth session on dental care. This session included the importance of frequent dental check-ups, proper care of the teeth and gums. Instruction was on proper brushing and dental flossing. Included also was information about how eating and foods affect dental status.

A three-month follow-up was scheduled after the last session to check the progress of all the participants.

ii) Weight reduction program

A weight reduction program was conducted for a period of 12 weeks, with two sessions per week, each of one hour duration. The aim of the program was to provide an effective intervention such that clients could learn how to control their own weight, and the types of diet that were nutritionally adequate. Appropriate weight loss for individuals was defined. Classes included:

1. Week 1-2 - Diet Instruction
2. Week 3-4 - Exercise Instruction
3. Week 5-6 - Behavior Modification
4. Week 7-9 - Health Education (relationships of obesity to health problems)
5. Week 10-12 - Self-knowledge and Reinforcement

Participants were also given questionnaires and instruction during these sessions as follows:

1. Mood summary
2. Health education questionnaire
3. True and false questions on weight reduction
4. Outside speaker discussion self-image
5. Physicians speaking on health education
6. Following the 12-week program each client returned in 3 weeks for a follow-up weight and diet check.

This program was conducted and modified based on this experience. Phase II of the CHRP weight reduction program started 6/21/76. The following revisions were made:

1. Instructional session for one-half hour followed by one-half hour of exercise. Session 2 of the same week included a full hour of exercise.
2. Weeks 1-2 - Behavioral Modification
3. Weeks 3-4 - Diet
4. Weeks 5-6 - Health education
5. Weeks 7-9 - Benefits of exercise
6. Weeks 10-12 - Self-knowledge and reinforcement

We found it was better to have a guest to speak on Behavior Modification during week 2. During week 5 an outside speaker came in to speak on Health Education in relation to job employability. It was also better to have an equal number of participants in the weight reduction program so each person had a buddy to contact for outside support.

iii) Mental health and vocational counseling program

Individual and group sessions were available. Clients were encouraged to participate initially in individual counseling before being placed in group sessions. Group counseling sessions were considered as follow-up before entry into job training and employment. Sessions (individual) were weekly and of one-hour duration with coverage of the following areas:

1. Definitions of problems. Psychometric testing.
2. Setting up of short-term and long-term goals.
3. Subject matter
    - Community activity participation
    - Project development in the home
    - Improving interpersonal relationships
    - Coping with family problems
    - Overcoming emotional difficulties
    - Employment counseling
    - Counseling on job interview techniques
    - Job seeking skills
    - Realistic employment aims
4. Contractual arrangements.

Regular attendance of clients at treatment sessions provided under these programs was facilitated by offering clients assistance in obtaining child care and/or obtaining transportation in order to make attendance feasible. Clients were encouraged but not mandated to participate in the in-house programs appropriate to their needs. Those rejecting group action were counseled on a one-to-one basis. Services provided by these programs were not locally accessible to persons on public assistance. For each client within the programs, attendance, therapeutic compliance with program goals, change in health behavior and status as well as conditions contributing to noncompliance were recorded. When noncompliance extended to more than one program session, notification was sent to the client and to the client's caseworker at DSS or DSS/SAU.

c) Referrals

Active intervention clients, having health problems which required medical, dental or other health rehabilitation services, not provided by the in-house programs were referred to individual health care professionals or clinics or hospitals as required by their condition. Under CHRP, referral included overall client advocacy in the health care delivery system such that not only were appointments made with the health care professional and/or facility but also clients were taken when necessary to appointments and their needs fully explained after the first visit. In the instance that a client required special services over and above those normally covered by Medicaid, the CHRP physician would communicate with the local Medicaid authority to obtain necessary permission for the procedure. Such permission from Medicaid was required in the case of a client needing plastic surgery and when particular dental reconstruction was required. Selection of health care providers in the referral system was by CHRP physicians and staff.

d) Support services

CHRP avoided duplication of support services provided in the community. Whenever the need became apparent and clients were eligible for support services within the community pertaining to health, these were utilized. Such services included drug abuse and alcohol abuse units, nutrition services (EFNEP) and family planning services. Family planning services in Ithaca that were utilized included Planned Parenthood and in Syracuse, the Onondaga County Family Planning Clinic system.

e) Follow-up

Follow-up of clients was at three, six and nine months after their entry into the program whether they were in the active intervention or control group. At the time of follow-up, client progress was documented and new health problems recorded. In addition, anthropometric measures and the MMPI hypochondriasis test were repeated. Follow-up records also were completed with respect to the client's employment and welfare status. When clients had completed their period of active association with CHRP and were already either in job training programs or in employment, three-month follow-up sessions might be waived and information obtained on client progress through use of mailed forms. The latter option was utilized only in those cases where the client would not be persuaded to return to the respective unit at scheduled or alternate times.

D. Characteristics of the Total Sample

1) Demographic characteristics

The total sample group consisted in 264 men and women who were residents either in Tompkins County or in Onondaga County (including the City of Syracuse) in Upstate New York. Among these clients there were 79 men and 185 women. The percent of women in our sample (70%) is almost identical to the national statistics for fiscal year 1974 for women (72%) in the WIN program. Since the guidelines for AFDC client referral differed between Ithaca and Syracuse, it was decided that in the analysis of the data, the two locations would have to be examined separately.

a) Age. The age distribution of the samples differed between Ithaca (Tompkins County) and Syracuse (Onondaga County) such that the Syracuse group was older than the group in Ithaca ($r=.20$, $p < .01$). In Ithaca, the mean age for the sample was 28.5 years, and 45 percent were 25 years or less in age. In Syracuse, the mean age of the group was 36.1 years and only 12 percent were 25 years or less in age (Table 2).

Table 2. Age, by project location

Age(Years)	Ithaca	Syracuse	Total
		Percent	
16-20	10	2	5
21-25	35	11	22
26-30	27	11	19
31-35	12	23	18
36-40	5	23	16
41-45	4	12	8
46-50	6	16	11
51-55	-	2	1
56-60	1	-	-
	100%	100%	100%
N reporting	116	142	258

b) Marital status. At the time of entry into CHRP for health evaluation, 24 percent of the Ithaca sample stated that they were married and 26 percent of the Syracuse sample indicated their marital status in this category. There were more single and divorced persons in the Ithaca sample than in the Syracuse group. In the Ithaca group, there was a lower percentage of persons who were separated than in Syracuse. The number of persons widowed in the two groups was similar (Table 3). Both in the Ithaca and the Syracuse sample, marital status was age dependent ($r=.29$, $p <.001$). In Ithaca in particular, significantly more of the clients under 30 described themselves as single.

Table 3. Marital status, by project location

Marital Status	Ithaca	Syracuse	Total
		Percent	
Married	24	26	25
Single	33	17	25
Divorced	23	30	27
Separated	17	23	20
Widowed	3	4	3
	100%	100%	100%
N reporting	112	139	251

c) Number of children. For clients with families, number of children was quite variable. For the 253 clients in the sample from whom such information was available, the mean number of children was 2.7 per family, but 18 percent of the clients had no children and 13 percent had 6 or more children (Table 4).

Table 4. Number of children, by project location

Number of children	Ithaca	Syracuse	Total
		Percent	
None	28	10	18
1 child	22	13	17
2 children	17	17	17
3 children	17	17	17
4 or 5 children	12	23	18
6 or more children	4	20	13
	100%	100%	100%
N reporting	117	136	253

The number of children per client was age dependent ($r=.61$, $p < .0001$) which was also reflected in a significant correlation between number of children and project location ($r=.32$, $p < .001$), since clients in the Syracuse project were also older than those in the Ithaca project.

For females with children, the age at the time of the first pregnancy tended to be young, with 69 percent of these women having had their first pregnancy before they were 20 years of age. The mean age of the first pregnancy was 18.7 years with no differences between the two projects.

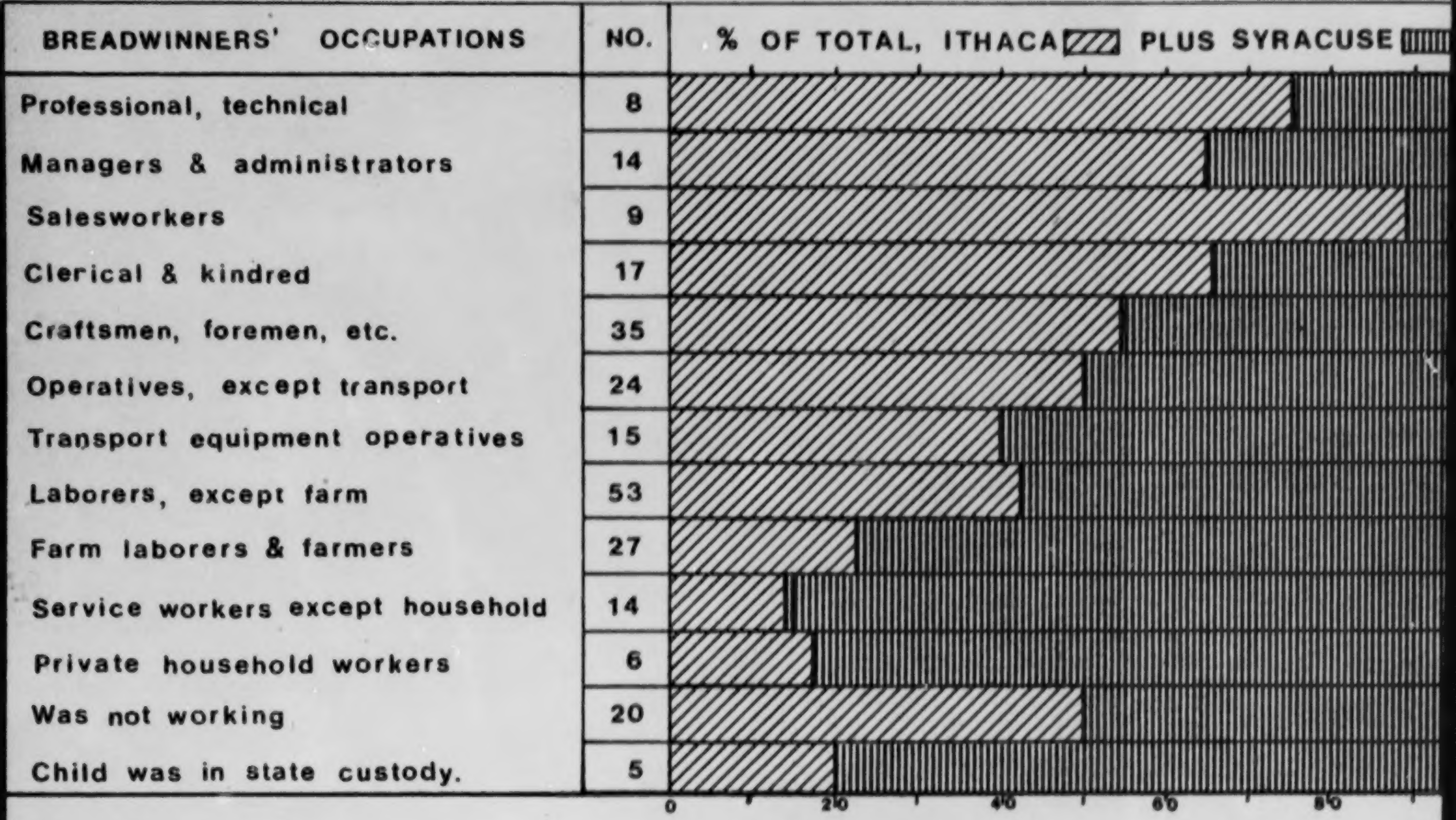
d) Education. In general, the educational status of clients was very limited, as can be seen in Table 5. Twenty five percent of the clients had had an eighth grade education or less, while 33 percent had received 12 years or more of schooling. In comparing these figures with those reported in the Manpower Report of the President (12), it would appear that the clients in the CHRP project had less education than had the enrollees in the national WIN program. Figures reported for fiscal year 1974 for WIN enrollees showed that 10 percent of the population had less than an eighth grade education and 40 percent had 12 years or more of schooling.

Table 5. Last grade completed in school, by project location

Grade Completed	Ithaca	Syracuse	Total
		Percent	
8th grade or less	13	36	25
9-11th grade	42	42	42
high school graduate	32	20	26
schooling beyond high school	13	2	7
	100%	100%	100%
N reporting	115	140	255

The number of years of schooling was significantly related to project location (r = .32, p < .001) with clients in the Syracuse project having less education than those in the Ithaca project. Number of years of schooling was also age related (r = -.32, p < .001) with older persons having less education than younger ones. Another interesting correlation with education was that of number of children (r = -.27, p < .001), indicating that those with more children tended to have less education. As would be expected, there was an inverse relationship between level of education and the age at first pregnancy, with the mean age of school leaving for women at 16.6 years. For men, the mean age of school leaving was 17.3 years.

e) Socioeconomic status of origin. It was found that the socioeconomic status of origin of the Syracuse clients was lower than that of the Ithaca clients. These differences were defined from responses to the question: "What was the breadwinner's occupation when you were 10?" While in both the Ithaca and the Syracuse samples, the family breadwinner was most likely to be a laborer, more of the Ithaca family breadwinners had been craftsmen or in a higher occupational category. The reverse was true in the Syracuse sample. Looking at this in a different way, for each of the lower occupational categories, greater percent of the total were in the Syracuse group and for the higher occupational categories, a greater percentage were in the Ithaca group (Figure 1). The socioeconomic status of origin if clients as determined by the occupation of the breadwinner when the client was 10 was not significantly related to age either in the Ithaca or Syracuse sample. The percentage distributions for occupational categories of breadwinner where client was 10 are shown in Table 6.



*Kendall's tau c = 0.03 p>.0001

Breadwinner's Occupation When Client Was Ten

Table 6. Occupational status of breadwinner when client was 10, by project location

Occupational Category	Ithaca	Syracuse	Total
		Percent	
Professional, technical	5	1	3
Managers and administrators	8	4	6
Salesworkers	6	1	4
Clerical and kindred	10	5	7
Craftsmen, foremen, etc.	14	12	13
Operatives, except transport	11	8	10
Transport, equipment operatives	5	6	6
Laborers, except farm	22	23	22
Farmers and farm managers	4	12	8
Farm laborers and farm foremen	1	5	3
Service workers, except private household	3	8	6
Private household workers	1	4	2
Was not working	9	8	8
Child was in state custody	1	3	2
	100%	100%	100%
N reporting	112	132	242

In response to the question "Who did you live with at the age of ten?", it is important to see that 61 percent of the total sample lived with both parents at the age of 10. Other persons with whom clients lived at this time of their childhood were a mother, a father, a grandmother, a grandfather, another relative, another non-relative, both grandparents or alternately one parent or another (Table 7).

Table 7. Person(s) with whom client lived at age 10, total sample

Category	Percent
Mother	19
Father	8
Both parents	61
Grandmother	2
Grandfather	1
Other relative	2
Other, non-relative	4
Both grandparents	2
One parent (at a time or unspecified)	1
	100%
N reporting	248

f) Welfare. Although by program definition clients entering the CHRP program were required to be on public assistance, there were, in fact, clients who entered the program while they were in the interstices of the welfare system. For the total sample at the time of entry, 24 clients (9%) were not currently receiving public assistance, 164 (62%) were on AFDC only, and 11 clients (4%) were considered to have been on AFDC and Home Relief, meaning that at or about the time of entry into the program, they were switched from one form of public assistance to another due to change in family status. Sixty-one clients (24%) were on Home Relief only.

2) Life setting*

a) Characteristics of the households. It was found that the number of people who lived with the client varied widely, though 12 percent of the sample lived alone, 20 percent lived with one other person, and 22 percent of the sample lived in a three person household. There were four clients who were living in a facility for drug abusers.

Twenty percent of household members living with clients were less than six years old, with 74 percent less than the age of majority (18 years). Most clients gave the marital status of other household members as single, which is in a large part explained by the number of children and adolescents in the household.

Examination of the relationships between the client and other household members showed that 71 percent of the other household members were children, 9 percent a spouse, 6 percent a male friend, 4 percent a female friend, and that very few subjects had a father or mother as a household member. This was to be expected since most of the clients in the program were AFDC recipients.

It is important to note that 47 percent of cases stated that they had emotional support from a friend, whereas 12 percent said that they had no emotional support from anybody. Other moderately common sources of emotional support cited included a parent, a relative, an agency or "support from God."

b) Work/educational status of other household members. The work or educational status of other household members was given as preschool for 15 percent of household members, school for 60 percent, and any kind of work or training only in the case of 12 percent of persons. There were 20 percent of households in which another household member was working and contributing to support. Reasons given why the 83 other household members could not work included that they could not find employment, that they had physical or emotional problems, that they were not trained to work, or that they were too old to work. Clients who cited household members as being physically or mentally unfit to work mentioned among possible reasons, acute medical problems, chronic medical problems, emotional problems, alcoholism, mental retardation, and a prison record. Other reasons for household members not working which were mentioned included no babysitter, that they could not read, that they had a handicapped child, that they were pregnant, that they were functioning as a housewife, that they had transportation difficulties, or that they were on work relief -- the latter two categories being mentioned only by one client each.

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*Tables for this section appear in the Appendix.

Among clients who indicated that one or more of their children of school age was not in a regular school (21 responses), 14 indicated that they had a child in a special school, three that they had mentally retarded children, one that the child was in trouble with the law, one that a child was working, and two that a child had dropped out of school and was not presently employed.

c) Public assistance status of other household members. Within the client's household, other household members might be on public assistance, evidenced by responses indicating other household members on Home Relief, Social Security, unemployment insurance, Disabled Veterans and government allotment. However, the largest group of other household members getting support currently were the clients' children or other children within the household (92%). Other nonwage income coming into the households included support from the client's father or ex-husband.

d) Residential mobility. Clients in the sample were characterized by short residence at one location, as indicated by the fact that approximately 60 percent had moved one or more times in the last year. In addition, 34 percent of the sample indicated that they expected to move within the next year, because they were not happy with their current living arrangements. There were, however, 12 percent of the clients who had lived in their current place for five years or more.

e) Characteristics of the housing unit. Most clients lived in an apartment (66%), with a small number living in trailers. Eighty-five percent indicated that their unit was owned by a private landlord, with only 11 percent living in public housing. In keeping with the public assistance status of the sample, 78 percent stated that the welfare department paid the rent. Most of the clients lived in one- or two-dwelling unit structures (55%), with about two-thirds of the clients stating that their home or apartment had five or more rooms.

Very few persons indicated that meals were included in the housing arrangement but of those who responded to the questions about cooking privileges, 97 percent indicated that these were available. Most of the clients did not share a kitchen, although of those clients who did say that they shared a kitchen, sharing was usually with fewer than five persons. Again, most of the clients indicated that they did not share bathrooms. The number of beds in the home varied widely, but four out of five indicated four or fewer beds. Only 63 percent of the clients indicated that they had a telephone, with 24 percent saying that they could be reached by phone through a friend and 22 percent indicating that they had no telephone at all. On the other hand, 90 percent of the clients had a TV set.

3) Employment histories

Data on employment histories are presented for the total sample, because there were no significant differences between projects in terms of job tenure or maximum pay categories. There were, however, interesting differences between males and females, thus the data are presented for these groups separately.

In the total sample, the mean total months employed for men was 79.5 months (median 48.1 months). The mean number of jobs held was 4.4. Among the women, the mean total months employed was 59.3 (median 35.6). The mean number of paying jobs held by the male clients was 4.4. For female clients, the mean total number of paying jobs held was 3.5.

For those who had held jobs as determined by the work history, the total time employed (job tenure) showed an interesting bimodal distribution for the sample such that it appears that 25 percent of the sample had been employed for less than 12 months, while 35 percent had been employed for more than five years (Table 8). As would be expected, job tenure was significantly related to age ($r = .38$, $p < .001$), older persons having been employed for a longer period of time.

Table 8. Total time employed for those who had held jobs, total sample

Length of Time Employed	Percent
6 months or less	14
7-12 months	11
1-2 years	13
2-3 years	10
3-4 years	10
4-5 years	7
5-10 years	18
10 years or more	17
	100%
N reporting	237

Comparison of maximum pay category by sex revealed that there were highly significant differences with men earning more than women (Kendall's tau c, $p < .0001$) (Table 9). Examination of the table indicates that for the women 33 percent of the sample had a maximum previous pay category of less than $2.00 per hour, but only 6.7 percent of the men were in this category. Both the men and women had, in general, been in very low-paying jobs. Analysis shows that a substantial proportion of the women had been earning less than the minimum wage.

Table 9. Maximum pay category, by sex[a] in total sample

Pay Category/Hour	Males	Females
	Percent	
Never worked	5	7
Less than $2.00	7	34
$2.01 - $3.00	28	46
$3.01 - $4.00	39	11
$4.01 - $6.00	13	2
$6.00 or more	8	-
	100%	100%
N reporting	75	181

[a] Pay category was significantly different by sex ($p < .0001$, Kendall's tau c).

4) Public assistance histories

Public assistance histories indicated that 42 percent of the clients had been on public assistance prior to the project period and that almost all of the clients (97%) were on Medicaid at the time of initial project contact.

It is important to note that in response to the question "How did you support yourself just before you applied for public assistance?", almost half (49%) of the clients stated that they had been working and supporting themselves. An additional 6 percent stated that both they and their spouses had been working. Nineteen percent had been supported by a working spouse, 11 percent by their parents, and the remaining 15 percent had some other source of support.

When asked, "Have you ever been on welfare before this?", 20 percent said that they had previously been on AFDC, 2 percent on SSI, 16 percent on Home Relief, 3 percent on food stamps only, and 5 percent on Medicaid only (Table 10).

Table 10. Percent who had previously been on public assistance and average duration, by type of assistance, total sample

Type of Previous	(N=264)	Number of Months			
Public Assistance	%	Mean	S.D.	Median	Mode
AFDC	20	34.7	42.6	12.3	12
Home Relief	16	16.9	20.2	11.6	6
Food Stamps only	3	16.7	18.7	6.0	3
Medicaid only	5	21.9	25.3	11.8	3
SSI	2	21.0	11.5	18.0	12

Of those clients who stated that they had previously been on AFDC or Home Relief, half had received this type of assistance for 12 months or less. Those previously receiving food stamps were in receipt of such for a median of 6 months. The median duration for those on Medicaid was less than one year.

Client responses to the question "Have you ever applied for SSI?" indicated that 17 percent of the total sample had applied for this form of assistance between 1963 and 1977. Only 5 percent of the clients had actually been in receipt of SSI in the past. For these clients the mean number of months that they had received SSI was 21.

It can be seen from Table 11 that females in the total sample had been on AFDC for a much longer period of time than had males ($p < .001$). There were no differences, however, either by sex or by project in length of time on Home Relief.

Again we observe differences between projects, this time in terms of length of time on public assistance. In Ithaca, clients had been receiving AFDC payments for an average of 48.2 months, while in Syracuse, clients had been receiving these benefits for an average of 78.7 months ($p < .001$). Undoubtedly there was an age effect, since clients in the Syracuse sample were, on the average, older than those in Ithaca.

Table 11. Mean (S.D.) total months on AFDC or Home Relief, for combined projects by sex and project by sex

Category	Total Months On					
	AFDC			Home Relief		
	N	Mean	S.D.	N	Mean	S.D.
Combined Projects						
Male	35	32.3	36.5	27	26.9	36.3
Female	113	78.5	71.0	46	36.9	47.1
Ithaca						
Total	54	48.2	49.3	48	27.0	34.9
Male	9	16.3	13.9	19	24.5	36.6
Female	45	54.5	51.4	29	28.6	34.3
Syracuse						
Total	94	78.7	73.7	25	45.2	55.3
Male	26	37.8	40.4	8	32.6	37.4
Female	68	94.3	77.7	17	51.1	62.0

5) Clients' agency contacts

In answering the question as to how they had "found" CHRP, 67 percent indicated that this contact was made through a social agency which is interpreted to mean that the client was referred through DSS or WIN/SAU. The other major source cited for client referral was the employment agencies (23%) which could mean the New York State Employment Service, WIN/DOL or CETA. Other means by which clients said they were put in touch with CHRP included the news media, friends and other agencies.

At the time of entry, only 14 clients (4%) out of 264 valid cases said they were registered with CETA.

At the same time, 112 (42%) stated that they were registered with WIN. On the question of whether they had worked or studied through a job-training program in the past, only 55 clients (21%) stated they had been in job-training programs.

Most contacts made with social agencies by clients during the last year had been with "welfare." The mean number of contacts within the Department of Social Services as stated by the client was 3.3. Among those clients who had had contact with the Family and Children's Service, the mean number of contacts was stated to be 5.5. Of the 9 clients who had had contact with Cooperative Extension, half had had at least 4 contacts. Among the clients who had been in contact with the Employment Service, the mean number of contacts was 7.4. Stated client contact with a private employment service indicated that there were only 5 reported cases during the last year. Among the 28 clients who indicated that they had had contacts with the vocational rehabilitation office, the mean number of contacts with this agency was 3.9. For the 46 clients who stated that they had had contact with a public legal service, the mean number of contacts was 3.6. On the other hand, for those 11 who had had contact with a private legal service, the mean number of contacts was 2.4. Only 8 clients had had contact with a loan or financial company and 19 had made other service agency contacts in the last year.

For the 87 clients who had been registered with WIN, the mean number of months with the program was 10.3. Only six clients stated that they had been with CETA programs at the time of entry and of the four who remembered how long they had been with CETA, the mean number of months that they had been with these programs was 7.7.

6) Health attitudes and practices

a) Self-perceived health restrictions preventing work. For both men and women, 67 percent believed that health restricted the type of job that they could get. Of those who perceived health restrictions on working, many reported "a bad back", nervousness while working, obesity, blackouts, bad eyesight, and bad legs which prohibited standing. Among the women, significantly more reported that their "bad legs prohibited standing" (46%) as compared with 24 percent among the men. (Table 12)

Of those who felt they had health restrictions, 21 percent of the men and 18 percent of the women stated that their doctors had advised them against working.

Table 12. Percent of clients who believed health restrictions prevented working, by sex of client and total population

Self-perceived health restrictions	Male	Female	Total
		Percent	
Bad back	38	42	41
Bad legs prohibit standing [a]	24	46	40
Nervousness	36	39	38
Overweight	14	25	22
My doctor advised against working	21	18	19
Bad eyesight	22	18	19
Blackouts	16	17	17
Skin complaints	4	7	6
Bad hearing	8	5	6
Toothlessness	4	7	6
Lameness	6	6	6
N who felt they had health restrictions	50	125	175

[a] Chi Square 6.36, $p < .02$

Significantly more of the Syracuse clients believed health restricted working (83%) as compared with the Ithaca clients (50%).

b) Health attitudes and awareness*. Client responses indicated that about three-fourths of the sample had had a physical examination in the last year. However, it was evident that the client's most recent physical examination might be by a variety of providers, some giving the examination for specific or limited types of health problems. We question whether physicians who saw the clients correctly interpreted symptoms. If they did understand that symptoms, as we discovered, were related to the common presenting disorders such as obesity, neuroses and alcoholism, then the inference may be made that little attention was given by the doctors to health education and counseling. Further, it seems that unless we are to discount clients' comments on their physician's advice against working, it must be assumed that rehabilitation of clients for employment was not a significant component of the health care received.

With regard to the physical examinations, it was reported that blood pressure was usually checked and urine examined. However, TB skin tests or chest x-rays were only provided for 44 percent of the sample. Hearing was checked for 58 percent and eyesight was checked for 64 percent of the sample, respectively. Whereas infrequent use of family planning clinics is indicated, responses may be biased by the inclusion of males among the respondents.

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*Responses to the questionnaire, "Health Attitudes and Awareness", are shown in the Appendix.

Underutilization of physician services is suggested by statements that almost half of the respondents would put off seeing an M.D. when sick and that 25 percent would only see a physician for emergencies.

Whereas only 20 persons (8%) in the sample reported that a physician had ever refused to treat them, 10 of these stated that refusal was because they were on public assistance.

In view of the prevalence of neuroses in the sample (see diagnoses), it is interesting that 43 percent expressed a desire to talk to a psychologist about their nerves.

Delay in seeing a dentist was admitted by 57 percent. However, 64 percent of the sample stated that they had a regular family dentist, and 55 percent had had a dental examination in the last year. Most of the sample (90.0%) had been given their last dental examinations by a qualified dentist.

Eye examinations, other than for automobile licenses, had been obtained by 52 percent of the sample in the last year, but when questioned about who checked their eyes, only 42 percent answered that they went to an ophthalmologist. In the sample, 64 percent wore glasses, but of those who wore glasses, the last time new glasses had been obtained was more than 4 years before for 32 percent of respondents.

Various reasons were given for delay in seeing a doctor including, most commonly, a claim that the client could take care of her/himself (71%). Transportation difficulties were cited by about one-fourth of the clients.

Common reasons for visiting the dentist included toothache (54%), need to have a tooth pulled (48%), and provision, adjustment or replacement of dentures (approximately 25%). Delay in visiting the dentist was most frequently because they were afraid (57%) and because they put off the visit until it was really needed (38%).

c) Eating, drinking and smoking practices. Consumption patterns for foods and beverages as well as cigarettes indicated a significant incidence of undesirable habits which were associated with health problems and which may explain particular groups of symptoms. Dietary deficiencies or specifically, deficiencies in dietary quality, are brought into focus by examination of food frequencies with respect to consumption of raw vegetables, cooked vegetables and milk which are all rich sources of micronutrients, including vitamins and minerals (Table 13). These foods also have a high nutrient to calorie ratio.

Evidence is presented that there were associations between total avoidance of one or another of these food categories.

Table 13. Client consumption of raw vegetables, cooked vegetables and milk, total sample.

# of times consumed	Weekly Cooked Vegetables	Weekly Raw Vegetables	Daily Milk
		Percent	
0	10	29	28
1	6	12	22
2	10	15	22
3	10	14	9
4	8	8	6
5	7	4	4
6	3	3	5
7	43	13	1
More than 7	3	2	3
	100%	100%	100%
N reporting	263	264	261

Using Pearson correlation, it was found that avoidance of cooked vegetables was associated with avoidance of fruit juice ($r = .20$, $p < .001$, $N = 263$), that avoidance of raw vegetables was associated with avoidance of cooked vegetables ($r = .10$, $p < .06$, $N = 261$) and fruit juice ($r = .13$, $p < .05$, $N = 261$) and that avoidance of daily milk was associated with the avoidance of fruit juice and cooked vegetables ($r = 0.15$, $p < .01$, $N = 261$ and $r = .16$, $p < .01$, $N = 261$, respectively). It is of further importance to find that avoidance of cooked vegetables is positively correlated with obesity as measured by triceps skinfold thickness ($r = 0.12$, $p < .05$, $N = 260$) but that avoidance of daily milk was negatively correlated with this anthropometric measurement ($r = -0.14$, $p < .01$, $N = 258$). Interpreting these relationships, we see that the fatter clients were more likely to avoid cooked vegetables but that the thinner clients were more likely to avoid daily milk.

Alcoholics were more likely to be thin than fat (alcoholism vs. skinfold $r = 0.14$, $p < .05$, $N = 261$) and were also likely to avoid intake of raw vegetables ($r = -.13$, $p < .05$, $N = 261$).

There emerged subgroups within the sample population whose poor eating habits detract from the attainment and/or maintenance of good health. In support of this interpretation, findings from other studies indicate that food frequency data can be used as an index of nutritional risk and that among indigent groups, the obese as well as alcoholics eat badly. Low intakes of vegetables, particularly raw vegetables, impose a risk of deficiency of B vitamins and, of the

B vitamins, particularly folic acid since this vitamin is largely obtained from such sources. It has been amptly demonstrated in our earlier studies, as well as by other investigators that among low income women, who are obese, folate deficiency is prevalent. Folate deficiency is also the most common nutritional deficiency disease among alcoholics.

In a study of women in family planning clinics, it was recently found that age and education as well as per capita income were significantly related to the total number of foods reported to be eaten. Tricep skinfold thickness and percentage standard weight for height for age were also negatively related to the number of foods reported to be eaten. Plasma folate which is highly correlated with folic acid intake was found in this study also to be correlated with age, education and negatively with tricep skinfold thickness and weight for height for age respectively (25).

Consumption of sodas was high and of those who responded to the question about soda drinking, 14 percent drank 4 or more glasses of soda a day. The prevalence of heavy coffee drinking was supported by the finding that 38 percent of those who drank coffee admitted that they drank 4 or more cups per day including 14 percent who drank 10 or more cups of coffee a day. Twenty-three percent, however, indicated that they did not drink coffee. Various reasons were stated for drinking coffee but it is to be noted that 10 percent of the respondents said they drank coffee when they were nervous.

From the total sample, there were 189 (72%) who admitted to smoking cigarettes and, of these, 46 percent smoked more than one pack a day. Among the smokers, respondents stated they smoked more when they were nervous, when they were out with people, when they were bored, when they were relaxing and when they wanted something to do. When asked why they smoked, respondents gave multiple reasons including 71 percent who stated it was habit, 29 percent for the taste, 52 percent to calm their nerves and 35 percent who said they smoked for something to do.

Among the clients, there were 70 percent who admitted to drinking alcoholic beverages but of these, only 8 percent stated that they drank one or more times a day. Times of drinking was misleading since many drinks could be taken on any one drinking occasion. Underreporting of alcohol intake was most evident because of objective signs of inebriation at the time of health evaluation and laboratory signs of alcohol abuse and/or hepatic dysfunction. Common times when clients stated they drank more alcoholic beverages were when they were out with other people, when they wanted to have a good time, and when they were relaxing. However, it appears from the responses of the question of "When do you drink more?", that a significant number of clients admitted that they drank more when they were depressed, nervous or bored. Common reasons for drinking were that they wanted to be sociable, that it had a calming effect, and that it helped them forget their troubles, that it gave them a good feeling and that they enjoyed the taste. Drinking from habit was also admitted by 12 percent of the respondents who drank.

Eating, drinking and smoking habits of our sample clearly point out a need for health counseling. A need for nutrition counseling is supported by information provided to us concerning probably deficiencies and excesses in the diet. The expense as well as adverse health affects of excessive coffee drinking, soda drinking, smoking and alcohol consumption is generally well known. It is, however, well to point out that consumption of sodas containing sugar will not only contribute to the daily energy intake and hence may influence development of obesity but also the sugar in the sodas will promote the incidence of dental caries. Heavy coffee drinking, rather than calming the nerves is liable to cause nervousness and also insomnia. Smoking not only carries the long-term risks of lung cancer but also of exacerbation of the symptoms of cardio-vascular and lung disease. Smoking is also a major cause of coughing, breathlessness and reduced vital capacity. The long-term effects of alcohol abuse include the major problem of dependence and of alcoholic diseases including hepatitis, cirrhosis of the liver and alcoholic brain syndromes. More immediate effects of binge drinking or daily alcohol abuse include the development of headaches, blackouts, indigestion, and insomnia. It is our opinion that the drinking and the smoking behaviors of such sample groups as this who are on public assistance may contribute to the health problems which they state as work limitations. A vicious circle is obvious in that unemployment would also be condusive to the development of these habits more especially among people who do not have the educational or social advantages to participate in more health giving activities.

7) Current health complaints

The ten most common health complaints cited at the time of entry of clients into the program for health evaluation were frequent nervousness, frequent tiredness, breathlessness, backache, cough, frequent headaches, insomnia, indigestion, palpitations, and stomach pain (Table 14).

Interesting and important correlations were obtained between the number of current health complaints and other variables (Table 15). Among demographic variables, the number of current health complaints was positively correlated with age and negatively related to education. The number of complaints were positively related in number to the number of children and to the age of the youngest child and negatively correlated with the maximal previous pay category. The Syracuse sample presented with more health complaints than did the Ithaca sample (correlation of current health complaints with project). Clients stating that health restricted their work had significantly more current health complaints. It is interesting to note that the longer clients had been on AFDC, the more health problems they complained of.

Fatter clients had significantly more current health complaints as shown by the correlation between tricep skinfold thickness and current health complaints. Performance on the step test was negatively correlated with the number of current health complaints and with vital capacity.

Table 14. Current health complaints, total sample.

Health complaint	% who reported complaint (N = 242)
Frequent nervousness	61
Frequent tiredness	58
Breathlessness	55
Frequent backache	47
Cough	43
Frequent headaches	41
Insomnia	41
Flatulence/indigestion	39
Leg cramps	38
Palpitations	37
Stomach pain	34
Allergies	34
Swollen ankles	34
Frequent urination	31
Current hot flashes	30
Noises in ears or head	28
Gum tenderness	27
Arthritis	25
Constipation	20
Bleeding gums	18
Flat feet	18
Morning nausea	18
Toothache	18
Faintness	18
Skin rash	18
Diarrhea	16
Urinary incontinence	16
Seizures	6
Paralysis	4
Prolapsed uterus	4
Current pregnancy	1

Associations were also found between certain psychometric measures and the number of health complaints. IQ was negatively related to the number of current health complaints. Significant relationships were found between certain of the 16 PF factors and current health complaints such that clients who were emotionally less stable (Factor C) showed more health complaints and this was also true for clients who were unmotivated (Factor F). Clients who were depressed (Factor O) had more health complaints as did clients who were overwrought (Factor Q_4). Clients who had a higher score on the MMPI hypochondriasis scale also reported significantly more health complaints.

Table 15. Significant correlations between number of current health complaints and other variables, total sample.

Variable	N	r	p value
Age	241	.21	$< .001$
Education	224	-.14	$< .05$
Number of children	231	.24	$< .001$
Age of youngest child	187	.21	$< .01$
Maximal previous pay category	242	-.15	$< .05$
Project location	242	.18	$< .01$
Client felt health restricts work	242	.15	$< .05$
Duration on AFDC	173	.19	$< .01$
Triceps skinfold thickness	240	.19	$< .01$
Step test (lo score = fitness)	221	-.27	$< .001$
Percent vital capacity	229	-.21	$< .001$
IQ	242	-.13	$< .05$
16 PF factors			
C (hi score = emotionally more stable)	253	.20	$< .001$
F (lo score = unmotivated)	253	-.13	$< .05$
O (hi score = troubled)	253	.23	$< .001$
Q_4 (hi score = overwrought)	253	.17	$< .01$
MMPI hypochondriasis score	227	.71	$< .001$
Number of physical diagnoses	242	.33	$< .001$
Neurosis - D_x	242	.26	$< .001$
Alcohol - D_x	242	.18	$< .01$

The total number of physical diagnoses obtained from the health evaluations was positively correlated with the number of health complaints, as were the specific diagnoses of neurosis and alcoholism.

It is therefore clear that the number of health complaints is influenced not only by the presence of physical disease or conditions which may limit physical performance but also by emotional and mental health factors and situational problems as well.

8) Medical histories

Examination of medical problems by diagnosis during various periods of life has shown that a number of health problems occurring prior to school age in the total client population were either congenital in nature or were associated with sore throats and lung infections. For the school-age period disease entities, such as strabismus (cross-eye) and asthma which had been reported for the preschool years, continued to appear. In addition, for the school-age period, medical problems which approximated the adult pattern began to be reported. The reporting of drug dependence, neuroses and symptoms referable to the nervous system in the school-age period may, we believe, have adverse prognostic significance. Further medical/surgical neglect would account for the persistence of health problems from childhood, through adolescence to adult life, e.g., strabismus, late effect of injury, drug dependence and neuroses.

For the period since the clients left school, the nine most commonly reported medical problems were neuroses, back problems (vertebrogenic pain syndrome), disorders of menstruation, obesity, hypertension, symptoms referrable to the limbs and joints, alcoholism, sleep disorders and cholelithiasis (calculi in the gall bladder or in a bile duct).(Table 16). Since diagnoses as coded were based only on the reporting by clients, precise diagnostic categories must be examined cautiously because they depend on client memory and reporting. Data in the following tables show that several different terms may have been used to report the same conditions, e.g. neuroses and nervousness and debility, or headache and migraine, or bronchitis and bronchopneumonia. (26)

Table 16. Most frequently reported medical problems, by period of life.

Medical problems	ICDA Code	# clients
At birth		
Other congenital anomalies of limbs	755	4
Other congenital anomalies of musculo-skeletal system	756	4
Immaturity, unqualified	777	4
Ill-defined and unknown causes of morbidity and mortality	796	3
During preschool years		
Acute laryngitis and tracheitis	463	9
Asthma	493	7
Hypertrophy of tonsils and adenoids	500	6
Bronchopneumonia, unspecified	485	5
Streptococcal sore throat and scarlet fever	034	5
Strabismus	373	4
Pneumonia, unspecified	486	4
Appendicitis	541	3
Inguinal hernia	550	3
During school years		
Appendicitis	541	13
Anxiety depression	300	12
Acute tonsillitis	463	10
Hypertrophy of tonsils and adenoids	500	8
Strabismus	373	5
Pneumonia	486	4
Disorders of menstruation	626	4
Symptoms referrable to limbs and joints	787	4
Concussion	850	4
Asthma	493	3
Drug dependence	304	3

Table continues on following page.

Table 16. Most frequently reported medical problems,[a] by period of life, continued.

Medical problems	ICDA Code	# clients
Since leaving school		
Neuroses	300	62
Vertebrogenic pain syndrome	728	43
Disorders of menstruation	626	35
Obesity	277	28
Essential benign hypertension	401	28
Symptoms referrable to limbs and joints	787	24
Alcoholism	303	19
Special symptoms N.E.C.(includes sleep disorders)	306	16
Cholelithiasis	574	16
Varicose veins of lower extremities	454	15
Headache	791	15
Hernia of abdominal cavity (excludes inguinal)	551	14
Symptoms referrable to respiratory system	783	14
Nervousness and debility	790	14
Drug dependence	304	13
Diabetes mellitus	250	11
Appendicitis	541	11
Spontaneous abortion	643	11
Menopausal symptoms	627	10
Eczema and dermatitis, NOS	692	10
Synovitis, bursitis, and tenosynovitis	731	10
Symptoms referrable to genitourinary system	786	10
Asthma	493	9
Disturbances such as convulsions, spasm, dizziness, memory loss	780	9
Infections of kidney	590	9
Displacement of intervertebral disc	725	8
Other diseases of the eye	378	7
Hemmorhoids	455	7
Hypertrophy of tonsils and adenoids	500	7
Disorders of function of stomach	536	7
Calculus of kidney and ureter	592	7
Infective diseases of uterus, vagina and vulva	622	7
Arthritis, unspecified	715	7
Symptoms referrable to abdomen and lower gastrointestinal tract	785	7
Injury, other and unspecified	996	7
Myxedema	244	6
Migraine	346	6
Ill defined heart disease	429	6
Chronic bronchitis	491	6

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[a] Complete medical history tables appear in the Appendix.

9) Therapeutic drug usage

In order to examine drug use and abuse within the sample population, classification was by number of prescription drugs taken daily or more frequently and number of over-the-counter drugs taken daily or more frequently. Regular intake of prescription drugs was not excessive, with the mean number of prescription drugs taken daily or more frequently being 0.42, (minimum 0, maximum 4). It was found that 72 percent of the clients did not take prescription drugs on a daily basis. Similarly, intake of over-the-counter drugs, at least as reported, was not excessive with 85 percent of the clients reporting that they took these drugs less than once a day (Table 17).

Table 17. Number of therapeutic drugs taken daily or more often, by type of drug.

Number of drugs taken daily	Type of Drug Over-the-Counter	Prescription
	Percent	
None	85	72
One	13	18
Two	2	7
Three	0	3
Four	0	0
	100%	100%
N reporting	199	200

10) Physical and psychological examinations

a) Physical examination. The most common physical findings pertaining to present or past physical illness were dental caries, musculoskeletal deformity and functional loss as well as other musculoskeletal problems, cutaneous lesions including a variety of dermatoses, periodontal disease, eye defects, adventitious lung sounds indicative of bronchitis or asthma, heart murmurs and/or enlargement of varicose veins. (Table 18). In addition to these physical findings, 23 percent of 250 clients for whom positive signs were obtained displayed peculiar behavior during the physical examination or during the time that the medical history was obtained. Such peculiar behavior included disorders of affect, drunkenness and most commonly preoccupation with illness. Multiple abnormal physical findings were common.

Table 18. Percent of clients presenting with most frequently occurring physical findings [a] at physical examination.

Physical finding	% of clients (N = 250)
Musculoskeletal deformities	52
Dental caries and periodontal disease	39
Dermatoses	36
Abdominal scar	26
Defects of the eye	14
Heart murmur and/or enlargement	13
Adventitious lung sounds and other lung problems	12
Varicose veins	10

[a] Complete listing appears in the Appendix.

b) Anthropometry and physical performance tests. Routine anthropometric measurements confirmed a clinical impression of the prevalence of obesity particularly in the female clients. The mean percent of average weight for sex, for height, for age was 120.58 percent (S.D. 39.5). Whereas there were 8 percent of clients who were more than one standard deviation below the mean, there were 14 percent who were more than one standard deviation above the mean (N = 254) (Table 19).

Table 19. Anthropometry and measures of physical capacity, total sample.

Measurements	N	Mean	S.D.	Percent ± 1 S.D.	
				Below	Above
Anthropometry					
Percent arm muscle circumference	255	102.1	18.7	16	15
Weight (percent)[a]	254	120.6	39.5	8	14
Triceps skinfold measurement (mm)	261	26.5	13.8	17	7
Physical capacity					
Vital capacity (percent)[a]	251	89.3	20.4	14	6
%Handgrip (dynamometer reading)	260	72.2	24.8	12	17
Coarse motor ability (Seconds needed to put blocks in box)	242	64.9	23.1	7	14
Fine motor ability (N dowel-cotter pin sets done in 2 min.)	259	8.0	1.7	16	19

[a] Corrected for average values for age and sex and height.

Obesity, as determined by triceps skinfold thickness, was more common in females and was positively correlated with age, with the number of children, and with the age of the youngest child. Obesity (tricep skinfold thickness) was also related to the client's statement that health restricted ability to work, negatively to the maximal pay before coming into the project. Obesity was positively related to the number of current symptoms that the client reported. Obesity was related to an impairment in physical performance, as reflected by time of stopping the step test and performance with the handgrip dynamometer. Fatter people tended to be shorter (height vs. skinfold).

The clients in the Syracuse sample were more obese than those in the Ithaca group. Obesity was negatively associated with education and with successful employment or training (Table 20).

Table 20. Significant correlations between triceps skinfold thickness and other variables, total sample.

Variable	N	r	p. value
Sex	264	.30	< .001
Age	259	.34	< .001
Number of children	247	.32	< .001
Age of youngest child	202	.30	< .001
Client felt health restricts work	260	.14	< .001
Maximal previous pay category	260	-.20	< .001
Number of current health complaints	240	.19	< .01
Step test (lo score = fitness)	235	-.23	< .001
Handgrip dynamometer	260	-.27	< .001
Height	260	-.15	< .05
Project location	260	.42	< .001
Client got job or training during CHRP	260	-.13	< .05
Education	224	-.13	< .05

Arm muscle circumference, a measure of lean body mass and muscle development, showed a mean in the normal range when corrected for age and sex, but there were 36 clients with percent arm muscle circumference greater than one standard deviation below the mean and 38 clients with percent arm muscle circumference greater than one standard deviation above the mean (N = 255).

Both men and women showed lack of physical fitness. A mean vital capacity for the total sample corrected for sex, height and age was only 89 percent of the normal value. There were 35 clients who had a vital capacity more than one standard deviation below the mean and only 18 clients with a vital capacity greater than one standard deviation above the mean. While vital capacity, as expected, was greater in males than females, it was also greater in the Ithaca than in the Syracuse clients, when males and females were compared.

As might be expected, the handgrip dynamometer test was markedly influenced by sex with females doing less well than males as well as being positively related to height. Handgrip performance was negatively related to skinfold thickness, age, number of children, and age of youngest child. Certain employment variables were related to handgrip dynamometer performance. For example, handgrip was positively related to previous maximal pay. However, initial handgrip dynamometer performance was not found to be a predictor of success with respect to employment. There was, however, a significant difference with respect to project location, with the Syracuse sample performing less well than the Ithaca sample (Table 21).

Table 21. Significant correlations between measures of physical fitness and other variables, total sample.

Variable	N	r	p value
Handgrip dynamometer			
Sex	264	.74	< .001
Height	264	.61	< .001
Age	259	-.26	< .001
Number of children	247	-.16	< .05
Age of youngest child	202	-.21	< .01
Maximal previous pay category	260	.46	< .001
Project location	202	-.21	< .01
Coarse motor ability			
Number of children	247	.16	< .05
Age of youngest child	202	.23	< .01
Maximal previous pay category	260	-.23	< .001
Project location	264	.19	< .01
Client felt health restricts work	260	.18	< .01
Triceps skinfold thickness	260	.19	< .01
Fine motor ability	260	-.24	< .001
Fine motor ability			
Sex	264	.16	< .05
Number of physical diagnoses	264	-.19	< .01
Number of extrinsic handicaps	260	-.24	< .001
Project location	264	.32	< .001
Step test			
Percent arm muscle circumference	221	-.24	< .001
Sex	221	-.16	< .01
Age	221	-.14	< .05
Number of children	221	-.34	< .001
Number of current health complaints	221	-.27	< .001
With success	221	-.19	< .01

Although coarse motor ability, as measured by the number of seconds it took clients to put a fixed number of blocks in a box did not show significant relationship to the sex of the client, it was related to number of children and age of youngest child. There was a negative association with the client's statement that health restricted capacity for work. Stated more clearly, this means that those who stated that their health restricted work took longer to put the blocks into the box (motor ability vs. job restriction). It was also related, negatively, to maximal previous pay category. Similarly, clients who were fatter, as measured by skinfold thickness, took longer to put the blocks in the box. Poor performance with respect to coarse motor ability was also associated with low performance in fine motor ability as measured by the number of dowel and cotter pin assemblies which were put together in a fixed time (2 minutes). The correlation between coarse motor ability and fine motor ability was negative which actually indicates that poor performance in the coarse motor ability test was associated with poor performance in the fine motor ability test because coarse motor ability was lower if a longer time was taken to put blocks in a box and fine motor ability was measured by the more cotter pin assemblies that were put together. Fine motor ability was significantly related to sex of respondent with women performing better than men. It was negatively related to the number of physical diagnoses on the health evaluation and to the number of extrinsic handicaps. Both coarse motor ability and fine motor ability were related to project location with clients in Ithaca performing better on both tests than those in Syracuse.

Performance on the step test was related to percent arm muscle circumference suggesting that both are markedly influenced by physical fitness. There were also significant relationships between performance on the step test and age, sex and number of children. Performance on the step test was also related to success in placement. The reason that relationships between step test and positive outcome carry a negative sign pertains to the computation of the step test performance. In fact, those who performed well in the step test were more likely to be placed.*

c) Psychological evaluation.

i) Appraisal of social and mental health problems. At the initial interview for psychological evaluation common social and mental health problems which were ellicited included anxiety and fears (83%), depressed mood (63%), inappropriate appearance and/or behavior (46%), hypochondriasis (37%), social withdrawal (32%) and agitation (29%). In addition, family problems were frequently described including problems with children (36%), problems with the spouse (39%), problems with family members (26%), and problems with other people (34%). It is also of note that performance on the job was a problem for 30 percent and performance with housework was 27 percent of clients (Table 22).

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*STEPTEST is the duration of the step test exercise in seconds, divided by the difference between the pulse rate at rest and the highest pulse rate reached in the step test, the result then multiplied by 50. A high score represents less physical fitness.

Table 22 . Appraisal of social and mental health problems, total sample

Category	Percent of clients who had problem (N = 238)
Social problems	
Problem with spouse	39
Problem with children	36
Problem with other people	34
Performance problem on job	30
Housework performance problem	27
Problem with family members	26
Performance problem at school	5
Mental health problems	
Anxiety and fears	83
Depressed mood	63
Inappropriate appearance, behavior	46
Hypochondriasis	37
Social withdrawal	32
Leisure, daily routine	31
Agitation	29
Belligerance	28
Persecution or suspicion	25
Obsessions or compulsions	24
Disorientation, impaired memory	23
Sexual problems	19
Lack of emotion	18
Alcohol abuse	13
Suicidal thoughts	12
Delusions	11
Antisocial	11
Dependency	9
Suicidal gestures, acts	9
Assaultive acts	8
Narcotic and other drug abuse	6
Hallucinations	4
Grandiosity	2

The psychiatric social worker evaluated psychological problems among the clients and considered that of those clients that she examined 10 percent had no problem, 37 percent had a mild problem, 49 percent had a moderate problem and 4 percent had a severe problem. As a group, the Syracuse clients exhibited greater overall severity of psychological problems than did the Ithaca group ($r = .24$, $p < .001$, $N = 171$).

Responding to the question whether they had a sleep problem, 12 percent of those who answered indicated that they slept too much and 42 percent that they had too little sleep. We interpret these perceived aberrations of sleep pattern to reflect either intake of sedatives or boredom (too much sleep) or depression, excess coffee drinking, alcoholism or disorganized life style (too little sleep).

Responding to the question whether they had an eating problem, 36 percent of those who answered indicated that they ate too much, 18 percent that they ate too little and, only 1 percent that they ate irregularly. These answers could be influenced by obesity (ate too much), by anorexia due to alcohol abuse, by anorexia nervosa (weight phobia), or monetary constraints and poor budgeting, or by lack of home-cooked meals (eats irregularly) or by depression (eats too little).

A factor analytic approach was made to define particular groups within the sample who shared personality, mental and situational characteristics. Included in the factor analysis were evaluations by the psychiatric social worker pertaining to speech, mood, affective states, thought processes, disorders of perception, intellectual functioning, orientation, memory, judgment, insight, disorders of physical function, disturbances in social relationships and related signs and symptoms. (See Table 22 for a listing of social and mental health problems.) Coefficients of correlations calculated between each item contained in the evaluation and every other item were examined to determine which items were substantially correlated. The objective was to find sub-groups within the sample, isolated by factor analysis, who were more or less likely to be successful in employment and/or in job training.

The final factor analysis after rotation with Kaiser normalization revealed 11 factors which explained the intercorrelational structure among the responses. Based on correlations of the factors with other important variables, 4 factors were later deleted. The names given to the remaining 7 factors and hence to the personality-mental-situational groupings were: 1) social withdrawal, 2) sick role behavior, 3) adverse situational response, 4) antisocial behavior, 5) drug or alcohol dependent, 6) problem child, and 7) depressive state (profound or psychotic depression). (Table 23).

There were two factors which had prognostic significance with respect to employment or job training (variable defined as success). The "adverse situational response" factor which contained the variables disturbance with mate or spouse, depressed mood, easily upset, inferiority, absence of grandiosity, and absence of antisocial behavior was correlated with intervention (r = .20) and positively with successful placement (success r = .17) as well as positively to the level of subsequent employment (r = .18). It is of interest that this factor was characteristic of female clients (r = .24). We are of the opinion that when situational problems were responsible for emotional disturbances, there was a greater probability for rehabilitation through counseling. The factor entitled "depressed state", which

Table 23. Factors derived from factor analysis of psychological evaluation.

Factor		Factor Loading
1	Social withdrawal	
	Disturbance with family members	.25
	Disturbance in relation to other people	.65
	Anxieties, fears, phobias	.25
	Depressed mood, inferiority	.37
	Social withdrawal, isolation	.64
	Suspicion, persecution	.50
2.	Sick role behavior	
	Disturbance in relation with child	.53
	Performance disturbance at housekeeping	.62
	Somatic concerns, hypochondriasis	.37
	Inappropriate affect, appearance, behavior	.22
	Difficulty in daily routine, leisure time	.57
3	Adverse situational response	
	Disturbance with mate, spouse	.39
	Depressed mood, inferiority	.38
	No grandiosity	.30
	No antisocial attitudes	.33
4	Antisocial behavior	
	Disturbance with family	.24
	Disturbance with mate, spouse	.25
	Anger, belligerance	.62
	Assaultive acts	.60
	Antisocial attitudes, acts	.58
	Sexual problems	.24
5	Drug and alcohol dependent	
	Alcohol abuse	.59
	Narcotics, other drugs	.43
	Antisocial attitudes, impaired memory	.28
6	Problem child	
	Difficulties with performance in school	.51
	Difficulties with performance in job	.46
7	Depressive state	
	Sleeping problems	.47
	Eating problems	.51
	Depressed mood, inferiority	.33
	Somatic concerns, hypochondriasis	.46
	Inappropriate affect, appearance, behavior	.21

contained the variables sleeping problems, eating problems, depressed mood, somatic concerns, hypochondriasis, and inappropriate affect, appearance or behavior was correlated positively with age (r = .38), fatness (skinfold thickness) (r = .26), number of children (r = .29), and with the severity of psychological symptoms (r = .51) as well as to the statement of the client's belief that health restricted employment (r = .31). It was also correlated with the number of coded diagnoses (r = .22). This factor was negatively correlated with employment after entry into the project (r = -.17). This factor was also correlated with (16 PF) personality factors of being inhibited (PFH r = -.17) and lack of motivation (PFF r = -.20). We interpret these findings to mean that chronic and psychotic depression associated with sick role behavior and leading to severe work disability is less amenable to health intervention. Probably clients with these characteristics are not appropriate to job placement.

ii) MMPI Hypochondriasis scale. The hypochondriasis score, indicated the degree of sick role behavior. Mean score was initially above the average standard and 35 percent of clients had scores that were either in the high range (26%) or above that range (9%); both being indicative of severe hypochondriasis (Table 24).

Table 24. MMPI Hypochondriasis score at initial evaluation, total sample.

Score	Percent
Low (0-4)	15
Below average (5-8)	18
Average (9-11)	15
Above average (12-15)	17
High (16-22)	26
Above "High" (23-30)	9
	100%
N reporting	263
Mean =	12.5
S. D. =	7.1

The hypochondriasis score was significantly related to age such that the older the client was, the greater the degree and incidence of hypochondriasis. Hypochondriasis scores were significantly higher in the Syracuse sample. These scores were not, however, sex related. An interesting relationship was found between the level of hypochondriasis score and education in that those with the lower levels of education showed more hypochondriasis indicating that this was a coping behavior in such educationally limited persons.

As anticipated, hypochondriasis score was significantly related to the presence of neurosis and to alcohol abuse. Hypochondriasis was also related to obesity (triceps skinfold thickness). It was related to the number of physical findings as well as to specific complaints of headache, insomnia, nervousness and excessive tiredness. Lack of tolerance of the step test was exhibited by clients showing hypochondriasis.

It was also related significantly to the number of months that a client had been on public assistance though not to the number of months that a client had been on Home Relief. This may indicate a sick role behavior is used more as a mechanism for coping with problem situations in a family household than in other situations or possibly the difference between the relationships of hypochondriasis with AFDC, public assistance rather than with Home Relief may pertain to the overall duration on welfare. Hypochondriasis was also a coping mechanism used by clients exhibiting personality characteristics (16 PF factors) indicative of moralistic attitudes (PFG) or being troubled (PFO) and overwrought (PFQ$_4$) (Table 25).

Table 25. Significant correlations between hypochondriasis score and other variables, total sample.

Variable	N	r	p value
Age	248	.31	$<$ .001
Project	248	.30	$<$ .001
Education	211	-.18	$<$ .01
Neurosis - D_x	248	.35	$<$ .001
Alcohol - D_x	248	.20	$<$ .001
Triceps skinfold thickness	244	.21	$<$ .001
Number of physical diagnoses	248	.17	$<$ .01
Current complaint:			
Headaches	246	.40	$<$ .001
Insomnia	246	.41	$<$ .001
Nervousness	246	.40	$<$ .001
Tiredness	246	.52	$<$ .001
16 PF factors			
G (hi score = moralistic)	238	.20	$<$ .001
O (hi score = troubled)	238	.20	$<$ .001
Q_4(hi score = overwrought)	238	.19	$<$ .01

iii) Rotter I-E scale. The Rotter internal-external score indicated the extent to which persons believe that they can influence their own lives or the lives of those around them. Mean initial score was within the average standard value but 33 percent of clients had above average or high scores on this test showing that they believed they were unable to influence their own destinies. Women were less likely than men to believe that they could influence their lives or other people than did men or conversely they believed that they were influenced by external factors ($r = .13$, $p < .05$, $N = 240$). Those with less education were most likely to believe that external factors governed their lives and that they could not change the course of events ($r = -.14$, $p < .05$, $N = 205$) (Table 26).

Table 26. Rotter I-E score at initial evaluation, total sample.

Score	Percent
Low (0-4)	12
Below average (5-8)	25
Average (9-11)	30
Above average (12-15)	24
High (16+)	9
	100%
N reporting	241
Mean	= 9.8
S. D.	= 4.1

iv) Sixteen Personality Factors (16 PF) questionnaire. The 16 PF is designed to measure normal dimensions of personality. Form E of the test was chosen because it is designed for persons with reading ability below the sixth-grade level or as Karson and O'Dell (27) state, "it is particularly useful with people who have not had the usual educational advantages of our society".

In our study raw scores rather than standardized scores were used because there were no comparable populations on which standardized scores were available and according to Cattell (28) "... in much basic research, especially when experimental and control groups are to be compared, one generally does best to avoid norms and simply keep to raw scores."

Definitions of terms for high and low scores for each factor were developed for our study population. These are given in Table 27 along with the mean and standard deviation for each factor for our sample (range = 0-8).

Correlations between a number of 16 PF factors and the I-E scale were found to be significant. In addition, multiple health complaints were stated by clients who were less emotionally stable (PFC, $r = -.20$, $p < .01$, $N = 192$), unmotivated (PFF, $r = -.13$, $p < .05$), and troubled (PFO, $r = .16$, $p < .05$). Further discussion of the value of 16 PF factors in predicting success (whether client got job or training during CHRP) is presented in Section E.

Table 27. 16 PF, definitions of low and high scores, means and S.D. for CHRP study population.

	Definitions				
Factor	Low score		High score	Mean (N=196)	S. D.
A	Withdrawn	vs.	Outgoing	4.9	1.6
B	Less intelligent	vs.	More intelligent	5.9	1.8
C	Emotionally less stable	vs.	Emotionally stable	3.4	1.8
E	Passive	vs.	Assertive	2.7	1.8
F	Unmotivated	vs.	Enthusiastic	3.7	1.8
G	Expedient	vs.	Moralistic	5.4	1.6
H	Inhibited	vs.	Venturesome	2.7	2.0
I	Self-reliant	vs.	Seeking help	5.3	2.1
L	Trusting	vs.	Suspicious	3.5	1.8
M	Practical	vs.	Unrealistic	3.8	1.5
N	Naive	vs.	Socially aware	4.3	1.2
O	Complacent	vs.	Troubled	4.9	1.9
Q_1	Respects rules	vs.	Rebellious	4.4	1.8
Q_2	Group dependent	vs.	Resourceful	4.8	2.0
Q_3	Openminded	vs.	Prejudiced	4.5	1.7
Q_4	Determined	vs.	Overwrought	4.5	2.2

v) IQ tests. IQ tests were performed in all on 221 clients and for these, the median score was 96 percent of the normal with a range of 53 to 132. Among the clients who had tests of their intelligence, 211 completed the modified Beta test and of these, the mean score was 96.6. Another 12 clients completed the Wechsler IQ test. Of these the mean score was 95.9 (Table 28).

Table 28. Measures of intelligence, total sample

Statistic	Modified Beta	Wechsler IQ
N. cases	211	12
Mean	96.6	95.9
Median	98.6	96.5
Mode	106	--
S.D.	15.2	17.3
Range	53 - 131	70 - 132

d) Laboratory procedures. Examination of laboratory test values reveals that in general our study population showed little hematological or biochemical evidence of gross organ dysfunction. There was a low frequency of anemia as evidenced by hemoglobin, hematocrit red blood cell values and red cell indices. Abnormal renal function was rare, as evidenced by serum creatinine and blood urea nitrogen values. Diabetes was rare as shown by blood glucose values.

Abnormal liver function was present, as shown by elevated transaminase values, (SGOT and SGPT) in relation to level of drinking.* Alcohol abuse was associated with elevation of the mean corpuscular volume (M C V)$>$ 93 cuμ which supports a commonly observed association between high alcohol intake and macrocytosis (red blood cells larger than normal).

We conclude that routine health screening of clients for WIN or other manpower programs does not require extensive laboratory tests and that such procedures should be carried out only if so indicated by the medical history or physical examination.

In the event that a client is suspected of alcohol abuse or the symptoms point to this diagnosis, in spite of a negative history, the diagnoses would be supported by biochemical tests showing liver dysfunction and hematological examinations showing elevation of mean corpuscular volume (Table 29).

e) ICDA coded composite diagnoses.(26) The most common coded composite diagnoses (ICDA Codes) from the health evaluation which interfered with employability were: neuroses, obesity, dental problems, back problems and alcoholism. Other diagnoses coded from the physical examination are shown in Table 30.

The number of ICDA coded composite diagnoses were significantly correlated with number of health complaints, extrinsic handicaps, obesity, alcoholism and poor physical fitness as well as with hypochondriasis (overlay of sick role behavior).

The coded diagnosis of obesity was influenced by sex with more females found to be obese. The coded diagnosis of neuroses showed a relationship to sex with more females having neuroses, and relationship to hypochondriasis, depression and being overwrought.

The coded diagnosis of alcoholism was related to sex with more males being alcoholic. Alcoholics were more likely to have earned more in previous jobs, to have held these jobs longer. They were less likely to be obese and they reported more current complaints (Table 31).

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*For SGOT, Pearson $r = .30$, $p < .001$, $N = 110$;
for SGPT, Pearson $r = .18$, $p < .034$, $N = 102$.

Table 29 . Number and percent of clients whose laboratory findings were below or above the normal range for specific tests

Laboratory Test	Normal Values	Below		Above		Total N Cases
		N	%	N	%	
Blood Chemistry						
Alkaline phosphatase	9-35 units	0	-	39	(28)	134
Bilirubin	0-1.5 mg	0	-	4	(2)	132
Calcium	8.7-10.7 mg	4	(3)	2	(2)	125
Cholesterol	150-250 mg	10	(8)	18	(14)	120
Creatinine phosphokinase (CPK)	0-52	0	-	0	-	97
Glucose	70-115 mg	12	(7)	13	(7)	175
Lactic dehydrogenase(LDH)	56-150 I.U.	0	-	27	(20)	128
Phosphorus	2.5-4.5	5	(4)	3	(2)	122
Potassium	3.5-5.0 mEq/L	1	(1)	10	(9)	115
Total proteins	5.5-8.0 gm	2	(2)	10	(8)	121
Sodium	135-148 mEq/L	0	-	1	(1)	114
Transaminases						
Serum glutamic oxalic transaminase (SGOT)	11-38 U/ml	7	(5)	14	(9)	133
Serum glutamic pyruvic transaminase (SGPT)	13-41 U/ml	15	(13)	19	(15)	118
Urea nitrogen (BUN)	5-22 mg	2	(1)	1	(1)	182
Uric acid	2-7 mg	1	(1)	3	(2)	124
Hematology						
Cell counts						
RBCs						
Males	4.2-5.4 m/cu mm	2	(4)	13	(23)	56
Females	3.6-5.0 m/cu mm	1	(1)	15	(12)	122
WBCs	5,000-10,000 cu mm	22	(11)	15	(7)	193
Hematocrit						
Males	42-52 ml/100 ml	7	(12)	1	(2)	59
Females	36-46 ml/100 ml	9	(7)	9	(7)	134
Hemoglobin						
Males	14-17 gm/100 ml	4	(7)	8	(14)	59
Females	12-15 gm/100 ml	10	(7)	21	(16)	134
Mean corpuscular volume (MCV)	80-93 cu micron	5	(3)	32	(18)	178
Mean corpuscular hemoglobin (MCH)	27-31 µµg	7	(4)	64	(36)	179
Mean corpuscular hemoglobin concentration (MCHC)	32-36 percent	5	(3)	7	(4)	179

Table 30. ICDA coded composite diagnoses made at physical examination[a], total sample.

Diagnoses	ICDA Code	% of clients (N = 234)
Neuroses	300, 790	57
Obesity	277	33
Dental problems	521, 523, 525	24
Back problems	305, 306, 728, 787	19
Alcoholism	303	13
Hypertension	401	10
Scars, skin problems	216, 692, 702, 706, 709	10
Poor hygiene	---	9
Bronchitis	466, 491	8
Mild and borderline retardation	310, 311	7
Heart disease	427, 429	7
Arthritis	713, 729	6
Varicose veins	454	6
Defects, diseases of the eye	370, 377, 378, 380	6
Nutritional deficiencies	269	3

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[a] Diagnoses with ICDA codes, for each such sample group appear in the Appendix.

Table 31. Significant correlations between number of ICDA coded composite diagnoses and other variables, total sample.

Variable	N	r	p value
Number of ICDA coded composite diagnoses			
Number of current health complaints	242	.33	$< .001$
Number of extrinsic handicaps	264	.22	$< .001$
Neurosis - D_x	264	.14	$< .05$
Obesity - D_x	264	.38	$< .001$
Alcoholism - D_x	264	.26	$< .001$
Step test	239	-.29	$< .001$
MMPI hypochondriasis score	248	.17	$< .01$
Diagnosis of obesity			
Sex	264	.19	$< .01$
Diagnosis of neurosis			
Sex	264	.22	$< .001$
MMPI hypochondriasis score	248	.35	$< .001$
PFO (depressed)	253	.23	$< .001$
PFQ_4 (overwrought)	253	.29	$< .001$
Diagnosis of alcoholism			
Sex	264	-.19	$< .01$
Maximal previous pay category	264	.15	$< .05$
Mean tenure	264	.14	$< .05$
Triceps skinfold thickness	260	-.14	$< .05$
Number of current symptoms (complaints)	242	.18	$< .01$

f) Handicaps. Agerholm, 1975 defines an intrinsic handicap as "a disadvantage arising from the individual's own characteristics from which he cannot be separated". (19) According to this classification there are nine key handicap categories as follows: 1) locomotor, 2) visual, 3) communication, 4) visceral, 5) intellectual, 6) emotional, 7) invisible, 8) aversive, and 9) senescence. The Agerholm classification with the handicap components in various categories appears in Reference 19. With respect to our use of this system, category 9 was not used because of the age range of the population. Aversive handicaps include obesity, bad hygiene, decaying teeth, self-induced skin lesions that were visible and readily apparent congenital malformations.

For the total client sample, the most common handicaps were the emotional (30%), aversive (24%) and locomotor (21%). Within the group having emotional handicaps, most had neuroses and in the aversive handicap group most were obese and/or had evidence of bad hygiene. Locomotor handicaps included back problems. Only 13 percent of the total sample had no intrinsic handicaps and many had more than one intrinsic handicap. The mean number of intrinsic handicaps per client was 2.2 for the total sample (Table 32).

Table 32. Number of intrinsic handicaps, total sample.

Number of intrinsic handicaps	Percent
None	13
1	21
2	29
3	16
4	14
5	4
6	3
	100%

N reporting 250
Mean = 2.2
S. D. = 1.5

For both men and women, the number of handicaps increased with increasing age. The one broad handicap category which was the best predictor of failure to be successful in job training or employment was the communication handicap category which includes any handicap in hearing, speech, reading and/or writing ($r = -.13$, $p = < .05$, $N = 205$). It is also significantly related to duration of time on public assistance ($r = .15$, $p = < .05$, $N = 191$).

Common extrinsic handicaps included family problems (37%), lack of education and job skills (35%), housing and transportation difficulties (22%) and problems relative to persons outside the family (21%). Clients in many instances had more than one extrinsic handicap.

From examination of data on clients with various types of intrinsic handicaps, it was shown that according to the nature of the intrinsic handicap, so the association with extrinsic handicaps varied. For example, for those clients who had locomotor handicaps, 63 percent had family problems, 57 percent had inadequate education or job skills, 18 percent had problems with housing or transportation and 25 percent had handicaps in relating to others. On the other hand, for clients with communication handicaps, 27 percent had family problems, 91 percent had educational problems, 27 percent had problems with housing and transportation and 36 percent had problems in relating to others. For those with intellectual handicaps, 57 percent had family problems, 93 percent had educational problems, 50 percent had problems in housing and transportation and 43 percent had handicaps in relating to others. For those with emotional problems, 65 percent had family problems, 59 percent had problems with education, 38 percent had problems with housing and transportation and 45 percent had problems in relating to others. For those with aversive handicaps, many of whom were grossly obese, 61 percent had family problems, 53 percent had educational handicaps, 40 percent had problems in housing and transportation and 43 percent had problems in relating to others.

When extrinsic handicaps were examined in relation to their incidence in clients with neuroses, obesity, and alcoholism, again marked variation in the predominant extrinsic handicap is seen particularly in comparing the neurotic group with the alcoholic group (Table 33).

Table 33. Relationship, between extrinsic handicaps and diagnoses of neurosis, obesity, alcohol, among those with one or more extrinsic handicaps.

	Physical diagnosis		
Extrinsic handicap	Neurosis	Obesity	Alcohol
		Percent	
Family problems	65	57	65
Lack of education or job skills	52	61	45
Housing/transportation difficulties	30	33	45
Problems in relationship with persons outside family	32	30	65
N reporting	80	54	20

In examining the distribution of client handicaps in working versus non-working clients (clients employed as of March, 1978), it can be seen that 31 percent of those with family problems were working, 26 percent of those with educational handicaps, 34 percent of those with problems in housing or transportation and 23 percent of those who had problems with others. Further, in reviewing the additional incidence of specific intrinsic handicaps in those who became employed versus those who remain unemployed, it can be seen that 23 percent of those who became employed had locomotor handicaps, 20 percent had visual handicaps, 8 percent had communication handicaps and 22 percent had visceral handicaps -- that is handicaps pertaining to the heart, lungs or abdominal organs, 6 percent had intellectual handicaps, 28 percent had emotional handicaps, 11 percent had so-called invisible handicaps indicating seizures, blackouts, or recurrent headaches and 26 percent had aversive handicaps meaning that they had an unattractive appearance. A better understanding of the influence of handicaps on working can be gauged from the knowledge that many clients had more than one handicap. So, for example, 46 percent of clients with emotional handicaps also had locomotor handicaps, 57 percent of this group had visual handicaps, 68 percent had communication handicaps, 68 percent had visceral handicaps and 71 percent had intellectual handicaps.

E. Outcome

1) Determination of sample groups.

Following the health evaluation (physical and psychological), case conferences were held to determine disposition of clients. Clients found to have remediable health problems were randomly assigned to intervention and nonintervention (control) groups. In addition, some clients were excluded from either of the above groups for several reasons. The distribution of clients in each of these groups by sex and project are shown in Table 34 .

Table 34 . Classification of clients following initial health evaluation, by sex and project site (percent).

Client Classification	ITHACA			SYRACUSE			TOTAL		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Intervention	44	48	47	39	36	37	41	42	42
Control	31	35	33	32	38	37	32	37	35
Rejected: no problems	8	2	4	0	2	1	4	2	3
Rejected: Non-remediable	6	1	3	12	9	10	9	5	6
Client refused CHRP	5	9	8	5	7	6	5	8	7
CHRP rejected client	6	5	5	12	8	9	9	6	7
	100%	100%	100%	100%	100%	100%	100%	100%	100%
N reporting	36	81	117	43	104	147	79	185	264

a) Exclusion groups. The exclusion category henceforth designated as "nonremediable" consisted of 17 persons with chronic and disabling diseases. In all of these cases antecedent illness had either produced chronic organ damage with disability or chronic psychoses were present. Further, it is important to note that these persons had multiple health problems contributing to their work disability. Findings in the health evaluation of these persons are summarized below.

Female, age 35, organic brain damage, hypertension, mental retardation
Male, age 24, schizophrenia, undernutrition
Male, age 56, diabetes mellitus, diabetic retinopathy, chronic alcoholism, Dupuytren's contracture
Male, age 24, antisocial behavior, late effects of head injury
Female, age 37, delusional psychosis (schizophrenia)
Female, age 50, obesity, umbilical hernia, varicose veins, dermatitis, edema
Female, age 50, paranoid schizophrenia, deafness
Female, age 47, arthritis of spine, lumbar scoliosis, polycythemia, dyspnea
Female, age 33, hypochondriasis, anxiety neurosis, obesity, epigastric hernia
Male, age 28, confusional psychosis, poor hygiene, dental caries, partially edentulous
Female, age 31, severe bilateral visual handicap, vertebrogenic pain syndrome, obesity
Female, age 46, rheumatoid arthritis, cystocele, urinary incontinence, obesity with antecedent of congestive heart failure
Female, age 40, urinary incontinence, angina
Male, age 33, Kyphoscoliosis, obesity, emphysema, periodontal disease/dental caries
Female, age 41, mental retardation, visual handicap, vertebrogenic pain syndrome, hypertension, obesity
Male, age 40, late effects of pulmonary tuberculosis, hypertensive heart disease, pelvic tumor, vertebrogenic pain syndrome, anxiety-depression, hydronephrosis, obesity
Male, 33, radiculopathy (requiring neurological workup)
Male, age 40, seizure disorder, chronic carditis, dental caries

Complete documentation together with significant antecedent events pertinent to their recent medical problems appears in the Appendix.

Clients were rejected by CHRP who already had adequate medical care or were moving out of the area. Clients who refused participation in the CHRP project did so after or in the middle of health evaluation. In certain of the cases, where clients rejected the program, there was a misunderstanding on the part of the client that CHRP was a health agency which would give them documentation of health problems which would make them ineligible for work. Clients with "no health problems" were those who had no health disorders which would interfere with employment.

b) Intervention and control groups. In data analysis, comparison was made of the demographic and health-related characteristics of the active health intervention and the control groups in order to determine if there were any significant differences between the two groups. Demographic characteristics including age, sex distribution, number of children, and education were similar, as was the total duration of past employment. Self-perceived health related job restrictions, hypochondriasis score, IQ score, and the number of current symptoms per client showed no significant group differences. The distribution of physical diagnoses were also similar. The incidence of neuroses, obesity and alcoholism, as well as all intrinsic handicaps, other than emotional handicaps, was similar in the two groups. Emotional handicaps were more frequently recorded in clients of the intervention group.

2) Predictors of success.

Successful outcome (dependent variable) was defined as entry into employment and/or job training while the client was in the CHRP program. Evidence of differences in success for the Ithaca and Syracuse clients is presented in Figure 2. For the Ithaca sample 65 percent of the intervention group and 41 percent of the control group were successful, compared with 25 and 22 percent of Syracuse intervention and control groups, respectively.

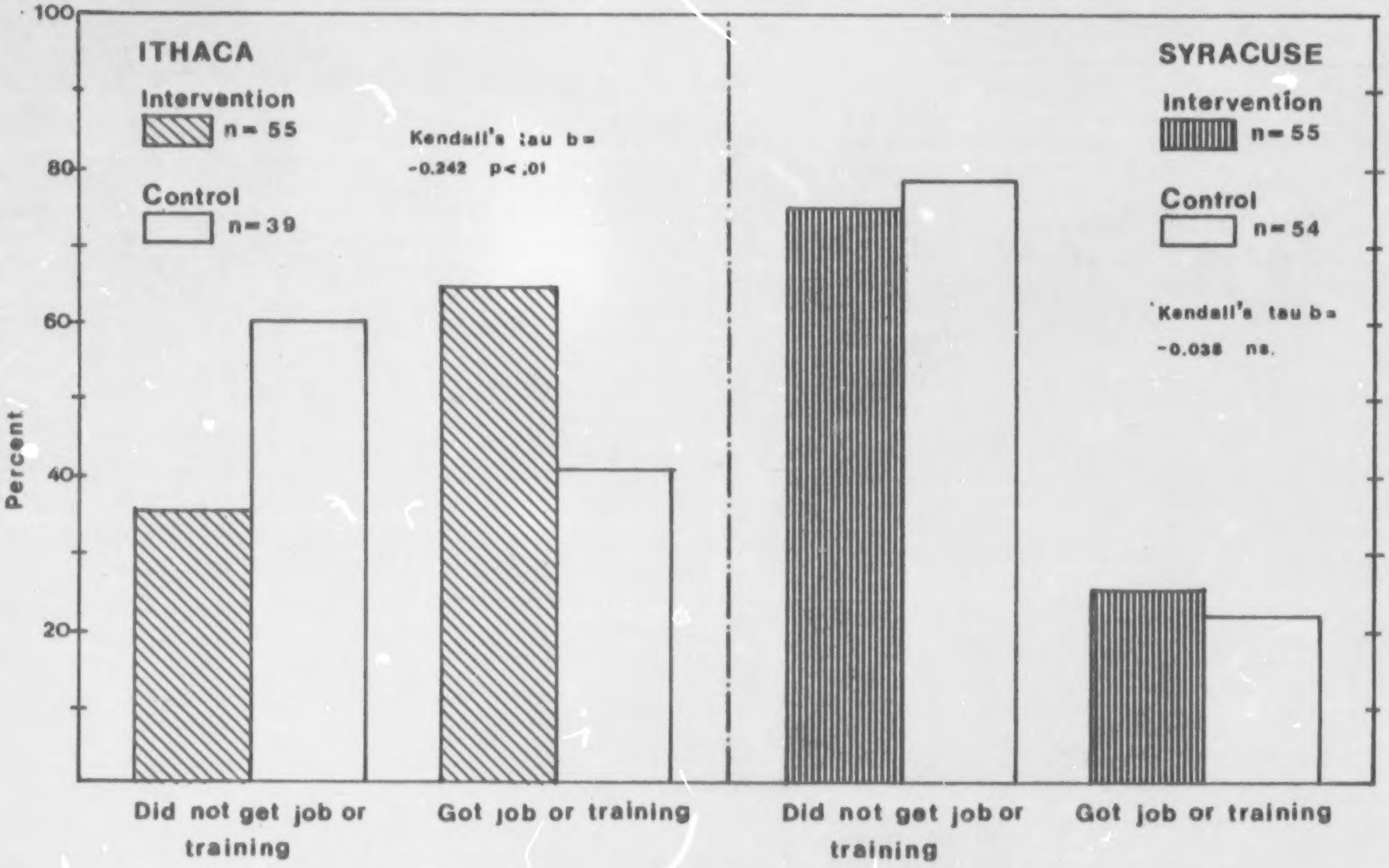
Predictive indices which allow determination of the probability of successful outcome from information derived from client evaluation were developed from stepwise regression analysis (29). The same variables were entered into the analyses for all the subgroups on which stepwise regressions were computed. The dependent variable in all analyses was successful outcome (entry into employment and/or job training).

The most constant predictors of success with respect to placement in jobs or in placement can be divided into health and nonhealth categories.

Health variables which were positive with respect to employability included absence of any statement by the client that his/her health interfered with working indicating greater motivation for work and less sick role behavior as well as less disability.

Fitness, as determined by the ability of the client to perform exercise without marked elevation in the pulse rate was also important as a predictor of success. Absence of obesity was another predictor of increased employability which indicates, on the one hand, that obese persons were less likely to get jobs owing to prejudice on the part of the employers and employment counselors, and, on the other hand, that their attitudes may be realistic concerning the health problems of obese people in the work force. It is, however, important to reflect that obesity is associated with low socioeconomic status of origin, to lack of education and lack of physical fitness as well as likelihood that a client will complain that his/her health is a work handicap.

Figure 2.



Effect of Intervention on Whether Client Got Job or Training During CHRP

Nonhealth variables include higher socioeconomic status of origin. We interpret this to mean that men and women who do not have to escape from a recurring poverty cycle have a greater chance to be successful. The presence of another household member who is working and contributing to the household budget had a positive effect and we would infer that in this instance the client was motivated to move away from welfare dependence, since it may be assumed that the earnings of the other household members were insufficient to make this possible. Better education was also an important determinant of increased employability, since the range of job slots open to persons with more education is increased.

Clients who came back for scheduled follow-up visits were more successful than those who did not which indicates an important effect of motivation and compliance.

The presence of a child under 6 in the household turned out to have a positive effect on employability, indicating that women who have been kept out of the work force by the presence of young children in the home may have aspirations towards upward social mobility and independence from welfare.

Several 16 PF factors were found to be predictors of success in employment or training. A high score on PFO, interpreted to mean "troubled or anxious" (concerning home/welfare/health, etc.), was positively associated with success and may indicate that the "troubled" client may seek a better style of living.

A low value on PFQ_4, indicating "determined" and on PFM, meaning "practical" disposition, were associated with success.
Persons having these characteristics were more likely to become employed or enter training during CHRP (Table 35).

Table 35. Predictors of SUCCESS (whether client got job or training during CHRP), stepwise regression for selected groups.

Variable	Beta	F value	Simple r
Syracuse (N = 80, $R^2 = .34$)			
Child under 6	.33	8.90	.25
PFO (hi score = troubled)	.23	4.98	.24
Education	.34	10.14	.16
Step test (lo score = fitness)	-.17	2.55	-.16
Returned for follow-up	.19	3.61	.22
Client felt health restricts work	-.12	1.37	-.18
PFM (lo score = practical)	-.15	2.05	-.20
Maximal previous pay category	-.16	1.86	-.01
Triceps skinfold thickness	-.15	1.85	-.16

Table continues on following page.

Table 35. Predictors of SUCCESS (whether client got job or training during CHRP), stepwise regression for selected groups.

Variable	Beta	F value	Simple r
Ithaca (N = 94, R^2 = .40)			
Returned for follow-up	.28	8.86	.29
Education	.25	4.18	.25
Step test (lo score = fitness)	-.20	4.59	-.20
Intervention vs. control	-.14	1.91	-.27
Communication handicap	-.15	2.84	-.19
Socioeconomic status of origin	-.14	2.09	-.23
Member household works and helps support	.18	3.74	.19
PFI (lo score = self-reliant)	-.11	1.11	-.14
Child under 6	.09	.83	.08
PFO (hi score = troubled)	.18	2.78	.13
PFQ_4(lo score = determined)	-.19	3.18	-.11
Emotional handicap	.12	1.65	.04
Triceps skinfold thickness	-.13	1.51	-.15
Control, both projects (N = 55, R^2 = .50)			
Child under 6	.39	8.24	.33
PFI (lo score = self-reliant)	-.23	3.42	-.31
Education	.45	12.77	.17
PFO (hi score = troubled)	.28	5.00	.22
Percent arm muscle circumference	.21	3.43	.11
Emotional handicap	.25	4.42	.20
Returned for follow-up	.25	4.19	.21
Maximal previous pay category	-.33	4.85	.08
Client felt health restricts work	-.25	3.92	-.12
Sex	-.24	2.18	-.01
PFM (lo score = practical)	-.16	1.81	-.21
Intervention, both projects (N = 64, R^2 = .55)			
Socioeconomic status of origin	-.21	4.01	-.33
Project location	-.27	3.83	-.33
Returned for follow-up	.31	9.61	.30
IQ	.29	6.89	.29
Member household works and helps support	.33	10.78	.26
Step test (lo score = fitness)	-.19	3.51	-.21
Client felt health restricts work	-.20	3.74	-.08
Age	.32	6.23	.01
PFI (hi score = dependent)	.16	2.37	.08
Triceps skinfold thickness	-.18	2.48	-.15
Total (N = 119, R^2 = .35)			
Returned for follow-up	.26	9.91	.26
Project location	-.09	.72	-.23
Step test (lo score = fitness)	-.26	9.75	-.19
Member household works and helps support	.18	4.80	.16
Education	.22	4.87	.25
PFO (hi score = troubled)	.21	4.18	.18
Triceps skinfold thickness	-.13	1.86	-.17
PFQ_4(lo score = determined)	-.13	1.72	-.04
Socioeconomic status of origin	-.13	2.30	-.21
Child under 6	.10	1.53	.26
HINT (headaches, insomnia, nervous, tired)	.11	1.55	.00
Communication handicap	-.09	1.19	-.18

3) Change in client status.

a) Change in health status. In the following section, alterations in health status are given for all objective measurements that were obtained.

i) Anthropometric. For the entire sample (Ithaca and Syracuse) who returned for follow-up, mean gain in body weight was 0.9 pounds. The total returning Ithaca group showed a mean weight gain of 1.9 pounds with the Ithaca intervention group gaining a mean of 1.6 pounds and the Ithaca control group gaining 6.5 pounds. In Syracuse, the returning total and intervention groups gained a mean of 2 pounds. Examination of weight changes by weight group, expressed as percentage weight for height for age showed that for total follow-up group, those who were underweight (less than 90 percent for weight for height for age) gained weight during the project and that underweight Ithaca clients gained more than Syracuse clients. Weight losses during the project occurred in Ithaca and Syracuse clients who were initially overweight (equal to or greater than 130 percent of weight for height for age). Weight changes in the total Ithaca and Syracuse groups were not influenced by intervention.

For Ithaca clients who were underweight or within normal weight, triceps skinfold thickness was similar at follow-up to that at the initial visit. This indicates increased muscle mass rather than fatness. Ithaca clients who were obese (150 percent of body weight for height for age or more) showed a reduction in triceps skinfold thickness at follow-up. In Syracuse, underweight clients became thinner during the project and obese clients lost very little fat as reflected by changes in triceps skinfold thickness. No evidence was obtained that a decrease in obesity was associated with success as previously defined by entry into employment or job training.

ii) Physical performance. Changes in vital capacity were seen between initial and follow-up visits. However, there were no substantial gains or losses in this parameter and no relationship was found between change and vital capacity and intervention or success. Similarly changes in handgrip dynamometer readings could not be related to intervention or success. Coarse motor ability was substantially improved in successful Ithaca clients in the intervention group. In Syracuse, there was a small improvement in coarse motor ability from the initial visit to the time of follow-up but this was not associated with intervention or success. Change in coarse motor ability was measured by the alteration in time it took clients to put blocks into a box.

Improvement in fine motor ability was not related to intervention or success. Changes in performance of the step test did not indicate improvement as a result of intervention or success.

iii) Psychometric scores. A small reduction in the internal/external scores were found in the successful Ithaca clients in the intervention group and similarly successful Syracuse clients showed a reduction in the internal/external score in the direction of internal influence which means that the clients, at follow-up, were more positive about being able to direct their own lives. The most striking changes at follow-up were in the MMPI hypochondriasis score. Reduction in the score for the Ithaca group was associated with intervention and success. Similarly in Syracuse, reduction in hypochondriasis score was associated with success. Reduction in hypochondriasis scores for successful clients was such as to bring them into the normal range of values.

iv) Health complaints. In the Ithaca group, there was a reduction in the number of health complaints at follow-up which was significant in the intervention but not in the control group. In Syracuse, there was also a reduction in the number of health complaints at follow-up. Both in Ithaca and in Syracuse, a reduction in the number of health complaints was associated with success.

v) Health problems improved or solved. For clients who returned for follow-up, the number of health problems improved was correlated positively with education ($r = .32$, $p < .01$) as was the number of health problems solved ($r = .20$, $p < .05$). The number of health problems improved was correlated with a smaller number of initial health complaints, younger age, less obesity, higher vital capacity and personality factors of expediency and openmindedness. The number of health problems solved was also related to younger age and to greater vital capacity (Table 36).

Table 36. Significant correlations between number of health problems improved or solved and other variables, total sample (N = 114).

Variable	r	p value
Health problems improved		
Education	.32	$< .001$
Number of current health complaints	-.20	$< .05$
Age	-.45	$< .001$
Triceps skinfold thickness	-.20	$< .01$
Percent vital capacity	.25	$< .05$
16 PF factors		
G (lo score = expedient)	-.22	$< .05$
Q_3 (lo score = openminded)	-.30	$< .01$
Health problems solved		
Age	-.35	$< .001$
Percent vital capacity	.28	$< .01$
Education	.20	$< .05$

b) Change in employment/training. The mean number of days between client conference and the time of first employment was 97 for the intervention clients and 120 days for the control clients. The mean number of days between first employment and the termination date was 166 days for the intervention clients and 50 days for the control clients. For intervention clients only, the mean number of days between the client conference and the last rehabilitation contact was 133 days and between the initial examination and the last rehabilitation contact 156 days (Table 37).

Table 37. Time sequence.

Mean number of days between:	Intervention	Control
Client conference and first employment	97 (N = 45)	120 (N = 26)
First employment and termination date	166 (N = 30)	50 (N = 14)
Client conference and last rehabilitation contact	133 (N = 92)	
Initial exam and last rehabilitation contact	156 (N = 95)	

Data shown in Table 38 indicate a greater number of Ithaca clients employed, both among intervention and control groups, than in the Syracuse sample. The period of employment was also longer for a larger number of the Ithaca clients, because jobs appropriate to their health and skills were found.

Table 38. Employment during first nine months after client conference (or period of follow-up, if shorter).

Category	Ithaca Intervention	Ithaca Control	Syracuse Intervention	Syracuse Control
	Percent		Percent	
Not employed	28	32	70	78
Employed 90 days or less	17	8	9	4
91 - 180 days	9	19	7	7
181 - 275 days	28	11	2	4
unknown	18	30	12	7
	100%	100%	100%	100%
N reporting	53	37	54	54

Of the Syracuse sample, only one client entered the WIN-funded training program and none were accepted for WIN public service employment. Three of the intervention clients were classified as working WIN registrants at the completion of the program and one control client was in this category. In evaluating the Syracuse sample, there were no differences between intervention and control clients with respect to outcome in relation to employment or training because clients were placed in the unassigned recipient pool or were still in the deregistered category for CHRP participation. (Table appears in the Appendix.)

In Ithaca, a greater percentage of intervention clients were working or in training at the end of the project than were either the control group in Ithaca or both groups in Syracuse (Table 39). Syracuse figures for employment were similar to 1975 national figures for percent of AFDC mothers employed (13).

Table 39. Work status at end of project, by project and intervention category.

Work status at end of project	Ithaca Intervention	Ithaca Control	Syracuse Intervention	Syracuse Control
	Percent		Percent	
Not working	48	61	83	80
CETA, OJT or public sector employment	10	6	--	4
Private sector employment	42	33	17	16
	100%	100%	100%	100%
N reporting	48	33	48	49

Examination of present pay categories per hour for the Ithaca clients shows that 26 percent of the intervention clients and 29 percent of the control clients were earning between $2.00 - $2.99 an hour. For Syracuse, where very few persons were employed both in the intervention and in the control categories there are clients who are earning less than $2.00 an hour. In Ithaca there were a greater percent of intervention clients earning more than $3.00 an hour than control clients but no such difference can be seen in the Syracuse sample.

These same trends can be seen in the maximum known pay per hour that clients have received from their initial visit to the program until the present. In that period in Ithaca, 41 percent of the intervention clients and 38 percent of the control clients earned less than $3.00 an hour. For higher pay categories, a greater percentage of intervention clients than control clients in Ithaca earned more per hour. In Syracuse, 9 percent of intervention clients and 16 percent of control clients earned less than $3.00 an hour. For higher rates of pay, 19 percent of intervention clients earned $3.00 or more compared with 10 percent of control group (Table 40).

Table 40. Pay categories, by project and intervention category.

Category	Ithaca Intervention	Ithaca Control	Syracuse Intervention	Syracuse Control
	Percent		Percent	
At end of project				
Not employed	56	58	85	81
< $2.00 per hour	0	0	4	4
$2.00 - $2.99	26	29	2	4
$3.00 - $3.99	15	9	7	7
$4.00 - $5.99	3	4	2	2
> $6.00	0	0	0	2
	100%	100%	100%	100%
Maximum known pay category per hour from initial visit to end of project				
Not employed	29	46	72	74
< $2.00 per hour	0	0	3	4
$2.00 - $2.99	41	38	7	12
$3.00 - $3.99	21	12	16	6
$4.00 - $5.99	7	4	2	2
> $6.00	2	0	0	2
	100%	100%	100%	100%
N reporting	48	33	48	49

Among those who were successful in the project, as defined by the various criteria described above, women with children under 6 were as likely or more likely to be successful in the Ithaca and in the Syracuse projects. It is to be noted that both in Ithaca and in Syracuse successful outcome for these women was perhaps a reflection of their age and/or their shorter duration on welfare as well as intervention. We are cognizant of the fact that control clients may have been favorably influenced in their health management by the process of evaluation and being told of their health needs.(Table 41).

Table 41. SUCCESS, project and intervention category among women with child(ren) under 6 years.

Group		% successful	# of women
Ithaca:	control group	50	14
	intervention group	60	25
Syracuse:	control group	20	5
	intervention group	18	11

The created variable, "success", indicating entry into employment or job training by clients was related to other variables which were also indicators of successful outcome. Thus from a Pearson correlation matrix, it was shown that the level of present employment was positively related to success, as was whether or not the client was in employment at the end of the study and present pay category. Success was positively correlated with the occupational status of the bread winner when the client was 10. The occurrence of the minus sign is understandable because the higher the occupational status of the bread winner, the lower the assigned number. Success was positively correlated both with the IQ and the education of the client. Negative relationships with success in these correlations included age, the presence of a communications handicap, the client's statement that his/her job capacity was restricted by health and to obesity, and in the 16 PF test, to the determination of "prejudice" (Q_3) (Table 42, see also Table 35).

The level of present employment was related to education as was the present pay category ($r = .25$, $p < .001$, $N = 172$ and $r = .28$, $p < .001$, $N = 159$, respectively).

Thus we emerge with the image of the successful client being from a background of relative success, being of higher intelligence, better educated, younger, without a communications handicap who did not believe that health problems restricted work capacity and who was slimmer and who was more openminded.

Table 42. Significant correlations between SUCCESS (whether client got job or training during CHRP) and other variables, intervention and control groups combined.

Variable	N	r	p value
Level of present employment	178	.69	< .001
Employed at end of study	203	.49	< .001
Present pay category	165	.57	< .001
IQ	203	.16	< .01
Age	199	-.23	< .001
Client felt health restricts work	192	-.21	< .01
16 PF factor			
Q_3 (hi score = prejudiced)	172	.25	< .001

c) Change in public assistance.

i) Analysis of Medicaid data.

Analysis of Medicaid data shows that, in the full year prior to the project, average costs for the intervention and control clients were similar except in the charges for M.D. hospital visits. Differences in M.D. hospital visits are explained by the higher charges for two clients within the control group. (Table 43).

In order to examine differences between pre-project and project costs for both intervention and control groups, adjustments were made in the pre-project costs for the duration clients were actually receiving Medicaid. Using these figures, it can be seen that costs during the project period were higher for both groups but these differences are explained by the addition of Medicaid coverage of diagnostic services (e.g. laboratory charges) incurred as a result of project initiated referral as well as project-initiated referrals for therapeutic purposes.

Average per capita Medicaid charges during the project period were substantially higher for intervention than for control clients in the following categories: M.D. hospital visits, hospitalizations and surgery. (Table 44).

Table 43. Medicaid expenditures, full year prior to project and pre-project period adjusted, by intervention (N=110) and control (N=93).

Category of Medical Expenditures	Full Year Prior to Project				Pre-Project Period Adjusted[a]	
	Intervention		Control		Intervention	Control
	%[b]	Mean Cost	%	Mean Cost	Mean Cost	Mean Cost
M.D. office visits	51	31.43	56	27.73	13.11	10.35
M.D. hospital visits	20	8.90	18	15.74	2.27	4.35
Clinic visits	34	51.35	34	49.38	3.65	3.67
Hospitalizations	14	82.31	10	91.05	27.98	20.04
Emergency room visits	51	32.29		31.58	7.50	5.07
Contraceptive services	6	1.67	4	0.88	0.37	0.53
Optician/optometrist	13	.89	11	1.00	0.15	0.09
New glasses	21	6.12	24	6.94	1.48	2.14
Dental visits	34	27.47	32	19.03	10.70	8.59
New dentures	4	8.14	3	5.87	0.00	0.00
Podiatrist visits	4	0.56	3	1.33	0.00	0.00
Physical therapy	3	8.67	1	0.05	0.19	0.00
X-rays	14	2.72	25	13.76	1.27	2.22
Pharmacy charges	69	28.38	65	36.03	10.48	10.77
Appliances	2	9.46	8	9.13	0.16	0.05
Surgery	10	10.53	9	8.27	3.08	4.73
Other diag. procedures	2	0.31	0	-	0.15	0.00
Laboratory	24	4.99	29	6.71	2.31	1.03
Mental health visits	11	7.55	8	8.34	3.24	6.46
Transportation	32	8.14	31	9.63	4.22	3.74
Home health aide	1	0.11	2	0.94	0.00	0.00
Chiropractor	2	0.68	0	-	0.00	0.00

[a] Adjusted proportionately to number of days client was on Medicaid during project period.

[b] Percent who incurred cost for each category.

Table 44. Medicaid expenditures, project period and project costs and referrals, by intervention (N=110) and control (N=93).

Category of Medical Expenditures	Project Period				Project Responsible			
	Intervention		Control		Intervention		Control	
	% [a]	Mean Cost	%	Mean Cost	%	Mean Cost	%	Mean Cost
M.D. office visits	44	19.97	43	18.85	14	3.80	2	0.39
M.D. hospital visits	34	11.88	20	4.30	9	3.29	0	-
Clinic visits	27	25.66	29	23.70	3	0.47	1	0.43
Hospitalizations	12	101.66	3	11.34	4	20.91	0	-
Emergency room visits	36	13.71	22	13.17	4	1.16	1	0.29
Contraceptive services	4	0.91	3	0.46	2	0.39	0	-
Optician/optometrist	4	0.73	4	0.23	1	0.21	0	-
New glasses	10	2.89	10	2.16	5	1.13	0	-
Dental visits	29	16.16	33	15.88	4	2.00	0	-
New dentures	2	6.56	5	7.11	2	3.83	0	-
Podiatrist visits	3	0.65	3	0.46	2	0.46	0	-
Physical therapy	4	3.02	2	1.62	4	2.00	1	0.16
X-rays	17	5.10	14	4.00	10	2.03	2	1.07
Pharmacy charges	63	20.69	54	22.95	14	1.56	2	0.17
Appliances	2	0.42	4	5.75	2	0.19	0	-
Surgery	6	11.92	3	2.91	3	4.20	0	-
Other diag. procedures	7	0.95	2	0.32	5	0.87	2	0.32
Laboratory	72	21.44	63	17.36	72	18.66	60	15.44
Mental health visits	7	6.37	9	11.97	1	0.25	0	-
Transportation	32	7.15	28	10.10	4	0.46	1	0.23
Home health aide	1	0.11	0	-	1	0.11	0	-
Chiropractor	0	-	0	-	0	-	0	-

[a] Percent who incurred cost for each category.

ii) Welfare grants. Initially average monthly welfare grants per client were higher in Syracuse than in Ithaca and this difference was maintained at the end of the project when average monthly welfare grants had been reduced for clients in both localities. However, the reduction in average monthly welfare grants per client was similar in Syracuse and Ithaca (Table 45).

Table 45. Mean monthly public assistance grant (initial, final and change), by project.

Monthly Public Assistance Grant	Ithaca	Syracuse	p value [a]
	Mean		
At initial entry into CHRP	$243	$308	< .001
At end of project	132	221	< .001
Change in grant	-111	87	ns

[a] Analysis of variance

Reasons for reduction in welfare grants obtained from WIN/SAU in Syracuse and the Department of Social Services in Ithaca included employment, change in marital status or family size, clients accepted by other agencies: e.g. OVR or SSI, clients moved away, client failed to recertify or clients were sanctioned. Records were incomplete in that for certain clients there was missing information.

Among Syracuse clients our information shows that in the intervention group 12 percent had welfare grant reductions due to employment with a figure of 13 percent in the control group. In Ithaca, employment was the reason for grant reduction in 46 percent of intervention and 26 percent of control cases.

For further analysis, welfare grant reductions were annualized for both Syracuse and Ithaca clients and within localities and intervention or control groups, clients were divided into those who had worked 30 days or more during the project period ("working") and those who did not work for this length of time ("nonworking").

Monthly and annualized welfare grant reductions (AWGR) were not different when intervention and control clients were compared but clients who were employed for 30 days or more had greater welfare grant reductions than the "nonworking" groups in both Syracuse and Ithaca (Table 46).

Table 46. Annualized welfare grant reduction (AWGR) for those working ≥30 days and those working <30 days, by project and intervention category (mean values).

	Ithaca		Syracuse	
Work status	Intervention	Control	Intervention	Control
≥ 30 days	$1489	$1106	$2031	$1937
< 30 days	890	724	402	720

Despite greater success of "working" than "nonworking" clients with respect to welfare grant reduction, the duration of employment and pay categories were such as to prevent many clients from becoming independent of welfare.

4) Interpretation.

We are now in a position to be able to describe the characteristics of a client who is most likely to do well in a health rehabilitation service intended to fit him/her for employment. An apparent contradiction exists in that, whereas clients who initially believed that their health was too bad for them to work were less likely to be successfully placed. On the other hand, intervention clients in whom reduction in hypochondriasis was achieved, outcome was more likely to be successful. These findings are not contradictory.

Rather they serve to point out the different prognosis that exists for clients who have moderate emotional problems with hypochondriasis and those whose sick role behavior is engrained.

A rather similar differentiation of clients with respect to prediction of success can be examined with respect to physical health problems. In general, it is not specific diseases which either have a favorable or unfavorable prognosis but rather prognosis rests on the degree of physical fitness or impairment. Clients who are able and willing to perform simple physical exercise without gross signs of intolerance are more likely to respond favorably to rehabilitation. In short, moderate physical disability is easier to treat than severe physical handicaps associated with multiple or gross organ dysfunction.

Although we obtained several predictors or indices of success which were related to physical performance, it is to be understood that performance of tasks, such as the step test, the handgrip test, etc., is strongly influenced also by motivation and that if these tests are poorly performed, it suggests that that client is not trying to show you that he/she can do well at work. The fact that massive obesity mitigated against success can be explained in a number of ways but we think that the most probable explanation is that our very fat clients were most likely to come from a background of low socioeconomic status, to be less well educated, to have less motivation as well as impaired exercise tolerance. Their physical condition also limited their work capacity. A bad prognosis for rehabilitation in the presence of communication handicap is again easy to explain in that clients with this handicap had a lower IQ, less education and an impaired ability to understand verbal or written instructions which might form an important part of health education and counseling. It follows that a communication handicap would also be a major problem in employment or job training.

Favorable characteristics such as higher socioeconomic status of origin, better education and strong motivation are the same qualities which spell success in other clients.

It is clear that there are welfare clients who have greater or lesser capacity to respond to a health rehabilitation program such that they will be fitted for competitive employment. We do not believe however that this finding justifies a too stringent selection procedure with respect to clients who might be appropriate for health intervention. There were also a number of clients who showed objective signs of health improvement during intervention but who were not successfully placed. It is for these clients that we would suggest that justification of active intervention can be made on the basis that they might be employed in special employment situations temporarily or permanently.

5) Costs.

A broad separation of costs may be made into operational and research expenditures which were split in an approximate ratio of 1 : 1.

a) Operational costs. Operational costs can be subdivided into costs per project site and costs per client.

i) Costs per project. Costs per project (Ithaca and Syracuse) includedpersonnel, site renovation and rental for the facilities, transportation, telephone charges as well as permanent equipment and medical/office supplies. Personnel costs comprise two-thirds staff salaries as well as consultant fees. It was estimated that two-thirds of the time of full-time operational staff was spent on health evaluation, health intervention, client contact and follow-up as well as agency liaison. The project coordinator was additionally responsible for in-service orientation of WIN, CETA and other local agency staffs to the program and for staff training sessions. The part-time physicians, working in the Syracuse unit, were paid as consultants. In the Ithaca unit, since the physician was also the project director, no fee or salary was accepted as payment for medical services rendered at the project facility. However, in order to estimate a cost for services of an MD in the Ithaca facility, we have chosen to insert the summer salary of the director which approximates MD costs.

Site rental included costs of rental of space for health examinations, counseling and physical rehabilitation sessions and cost of utilities and housekeeping which were included in the rental agreement both in Ithaca and in Syracuse. Remodeling was carried out in Ithaca only and served to increase convenience and operational efficiency. Separate counseling and conference rooms were set up as well as an office where privacy of communications could be assured and confidential client records held in locked filing cabinets. Permanent equipment consisted of small instruments such as Lange skinfold calipers and handgrip dynamometers used for anthropometric and physical assessment, respectively. Health unit supplies included disposable items such as patient gowns, tongue blades, pharmaceuticals and small replacement parts for medical equipment. Books purchased included medical and nutrition texts as well as manuals and psychometric testing materials. Office supplies included stationery, printing costs for reporting forms, health education pamphlets, day books, account books and xerox charges.

Other costs included laboratory charges for follow-up hematologic and biochemical tests incurred because clients had lost eligibility for Medicaid (Title XIX) when they became independent of welfare assistance. Telephone charges included calls between the Ithaca and Syracuse facilities, long distance calls to local and state agencies, calls to physicians, record rooms in hospitals and clinics for clients' medical records as well as base charges.

Transportation costs included use of "state cars" in carrying personnel from one facility to the other or to area agencies as well as cost of transporting clients to and from their homes or to area health care units for diagnostic and therapeutic purposes.

Total operational costs for both projects were approximately $125,000. With the project sites in operation for approximately 28 months, average cost per project site per year was estimated to be between $26,000 and $27,000 per year.

ii) Cost/benefit analysis. Cost/benefit analysis was carried out using total project operational costs versus annualized welfare grant reduction (AWGR). All operational costs including personnel, site, health evaluation and intervention and other costs discussed above pertained to the overall outcome of the project. Costs were further analyzed in terms of clients entering employment for 30 days or more. In Ithaca more of the intervention than control clients worked 30 days or more during the CHRP project period. However, in Syracuse, there were no differences between intervention and control groups in percent of clients who worked 30 days or more.

We estimate that the cost per client in the total sample to be approximately $475 per client ($150,000 divided by 264 clients). Thus we arrive at the following return on investment for both clients who entered employment for 30 days or more and those that did not (Table 47).

Table 47. Return on investment, for those working $\geq$ 30 days and those working < 30 days, by project and intervention category (mean values).

Work status	Ithaca Intervention	Ithaca Control	Syracuse Intervention	Syracuse Control
$\geq$ 30 days	$3.14	$2.33	$4.38	$4.08
< 30 days	1.87	1.52	0.85	1.52

The return on investments of the project was cost beneficial over the WIN program figures for New York State and the WIN national program, which were $1.13 and $1.31, respectively, for those who entered employment for thirty days or more (30).

Further our impact has been best expressed by the senior administrator of the Department of Social Services for Onondaga County,

> "My staff and I would like to express our appreciation to you and your staff for the excellent medical evaluations and recommendations. These evaluations and recommendations were swift and exactly what we required

to assess the clients' employment potentials. The project not only saved valuable staff time and effort but also conserved County funds. The project was most valuable in quickly identifying clients as either employable or unemployable, thereby saving time and effort for clients, also. The Social Security Administration readily accepted the CHRP medicals for Supplemental Security Income eligibility."

b) Research costs. The largest category in research costs was for the salaries and hourly-rated payments to personnel. The salaries of the statistician, the computer specialist as well as the salary of the research specialist appointed as a program evaluator were accepted as 100 percent research costs as were the salaries of the secretary employed during the period when the final report was prepared and the part-time salaries of assistants engaged in tabulating Medicaid records, applying ICDA codes, coding and key punching operations. The full-time research staff were responsible for project design, preparation and administration of questionnaires to WIN regional directors, to local agencies and to personnel and clients as well as for data analysis and assembly of materials for the final report. With respect to operational staff, it was estimated that one-third of their time and therefore their salaries pertained to research. Research activities of the operational staff included pretesting of questionnaires, development and pretesting of in-house health intervention programs, evaluation of psychometric tests and tests of physical fitness, design of reporting forms and preparation of case summaries for the quarterly and final report to USDL.

The next major research cost was for computer usage at Cornell University. Long distance telephone charges were incurred in communication with WIN regional directors, in communication with health planning educators and administrators and in calls to local, state and federal agencies.

Transportation charges included use of the "state car" for consultations with area health personnel, WIN, Social Services and employment staffs in connection with the development of the demonstration model. Additional transportation costs were a round trip fare for the project director to visit WIN in Region IX and the University of California School of Public Health in Berkeley to obtain critical evaluation of the proposed demonstration model.

Books included ICDA manuals. Office supplies included stationery, printing and duplication costs and costs for preparation of the final report.

III. SURVEYS

A series of surveys were conducted between September 1977 and March 1978 to provide additional data for evaluating the project and for assisting in the development of the demonstration model.

A. Client evaluation questionnaire

A questionnaire was administered by the project evaluator in January-February, 1978 with respondents being CHRP intervention clients. Completed questionnaires were obtained from 41 clients in the Ithaca-Tompkins County project and 36 in the Syracuse-Onondaga County project. The questionnaire as can be seen from (Table 48) pertained to the original health problems of clients, as well as need for support services. The client evaluation of directions in which CHRP help them both over the range of their original problems and in the perceived support given by CHRP personnel tended to be rather similar in the two population sample groups. Common health problems cited by intervention clients at time of entry into the program included nervousness, overweight, underweight, dental problems, health problems needed further investigation, health problems preventing employment, as well as emotional problems with self-esteem. Non-health services which clients felt they had obtained during the project period included more commonly job training, help with job interviews, employment, help with agency contacts, legal aid, transportation and different housing. In examining the responses, it should be noted that at entry, clients said that they had had a problem with trusting others (in agency systems).

CHRP was considered to have been most helpful in dealing with nervousness, overweight, meal planning problems, dental problems, in finding a regular M.D. for clients, in providing exercise, in dealing with alcohol problems, in investigating health problems, helping with problems that had prevented employment, in giving education on over-the-counter drugs, in improving clients' personal appearance, in improving clients' self-esteem and in solving the problems of trusting others. As can be seen from (Table 103), there were some differences between the answers of the Ithaca and Syracuse clients. In respect to other types of assistance which clients believed that CHRP had afforded, clients believed that CHRP had helped them in getting into job training, in coping with job interviews, in employment (particularly in Ithaca), in getting into college, in making agency contact, in obtaining legal aid and in obtaining transportation. We were particularly interested in the response that CHRP had assisted clients in developing trust and we believe that this is evident of the quality of interpersonal relationships and counseling afforded by employees of CHRP.

Table 48. Effectiveness of intervention on outcome as reported by clients and of those, said CHRP helped.

		Had this problem			Said CHRP helped		
Q#	Type of problem	Ithaca	Syracuse	Total	Ithaca	Syracuse	Total
1.	Nervousness	54% (22)[a]	75% (27)	64% (49)	77% (17)	63% (17)	69% (34)
2.	Overweight	39 (16)	44 (16)	42 (32)	56 (9)	94 (15)	75 (24)
3.	Underweight	29 (12)	22 (8)	26 (20)	42 (5)	25 (2)	35 (7)
4.	Meal planning problem	15 (6)	14 (5)	14 (11)	33 (2)	60 (3)	45 (5)
5.	Dental problems	41 (17)	33 (12)	38 (41)	53 (9)	67 (8)	59 (17)
6.	Lack of a regular M.D.	17 (7)	36 (13)	26 (20)	42 (3)	69 (9)	60 (12)
7.	Lack of regular exercise	51 (21)	39 (14)	45 (35)	52 (11)	38 (16)	77 (27)
8.	Alcohol problem	20 (8)	14 (5)	17 (13)	63 (5)	80 (4)	69 (9)
9.	Health problem needing further investigation	46 (19)	67 (24)	56 (43)	68 (13)	50 (12)	58 (25)
10.	Health problem preventing employment	41 (17)	72 (26)	56 (43)	59 (10)	50 (13)	53 (23)
11.	Problem with use of OTC drugs	5 (2)	8 (3)	6 (5)	50 (1)	67 (2)	60 (3)
12.	Problem with appearance	17 (7)	17 (6)	17 (13)	86 (6)	50 (3)	69 (9)
13.	Problem with self-esteem	61 (25)	47 (17)	55 (42)	80 (20)	76 (13)	79 (33)
14.	Problem trusting others	44 (18)	42 (15)	43 (33)	89 (16)	93 (14)	91 (30)

[a] N. in parentheses

Number of completed questionnaires: Ithaca = 41; Syracuse = 36; Total = 77.

Table continues on following page.

Table 48. Effectiveness of intervention on outcome as reported by clients and of those, said CHRP helped, continued.

		Obtained this			Said CHRP helped		
Q#	Outcome	Ithaca	Syracuse	Total	Ithaca	Syracuse	Total
15.	H.S. equivalency class	20% (8)[a]	14% (5)	17% (13)	50% (4)	0% (0)	31% (4)
16.	Job training	27 (11)	17 (6)	22 (17)	91 (10)	100 (6)	94 (16)
17.	Help with job interviews	46 (19)	33 (12)	40 (31)	84 (16)	75 (9)	81 (25)
18.	Employment	59 (24)	25 (9)	43 (33)	63 (15)	33 (3)	56 (18)
19.	College	22 (9)	6 (2)	14 (11)	78 (7)	100 (2)	82 (9)
20.	Child care	15 (6)	8 (3)	12 (9)	50 (3)	0 (0)	33 (3)
21.	Agency contacts	66 (27)	69 (25)	68 (52)	85 (23)	80 (20)	83 (43)
22.	Legal aid	27 (11)	25 (9)	26 (20)	73 (8)	56 (5)	65 (13)
23.	Transportation	39 (16)	53 (19)	45 (35)	75 (12)	100 (19)	89 (31)
24.	Different housing	49 (20)	28 (10)	39 (30)	20 (4)	10 (1)	17 (5)

[a] N. in parentheses

Number of completed questionnaires: Ithaca = 41; Syracuse = 36; Total = 77.

B. Survey of welfare, employment and health agency personnel

Representatives of agencies which have had contact with the CHRP system, were interviewed, using a structural interview schedule, with regard to their opinions on present methods of health determination and the impact of the CHRP program. Responses indicated a lack of satisfaction with existent methods for health determination in the WIN system and in Departments of Social Services. The CHRP medical evaluation system was generally highly approved, though in Syracuse a representative from WIN/DOL thought that not enough information was provided with respect to the client's ability to perform specific jobs. Disadvantages of the current system which were cited included: 1) lack of standardization, 2) the fact that the physicians were not keen on making employability assessments, and 3) time lags on evaluations and reporting. An advantage of the present system was the use of standardized reporting forms with which the physician and client were both familiar. Disadvantages of the CHRP system were poor location (Syracuse) with respect to distance from WIN/SAU and DOL, CETA and health care units utilized for referral. Advantages of the CHRP system which were stated included the focus on employability, the timeliness and immediacy of the evaluations, daily communication with CHRP staff, the precision of diagnoses and the addition of information on hypochondriasis. Other advantages of the CHRP system included the follow-up and client assistance and the emphasis on work orientation.

In the circumstance that a standard health evaluation procedure should be developed under the demonstration model there was some disagreement on staffing and location of staff to carry out health evaluations.

In general, the respondents were very positive about the rehabilitation services that had been provided by CHRP, though the representative from WIN/DOL stated that the CHRP concept of rehabilitation was not well understood. Specific advantages of the CHRP rehabilitation system were believed to have been a financial savings, the availability of short-term rehabilitation, the location in Ithaca of the project at a neutral site, and, with respect to evaluation of outcome, the random selection of persons for health intervention. Other advantages were said to be the provision of health evaluation and rehabilitation by a single program and the large number of clients who had been seen by a small staff. It was felt that CHRP had increased the employability potential for many clients. Disadvantages cited included the fact that CHRP was outside the existent system(s) and that, therefore, they had no enforcement powers. In Syracuse, the location of the facility was again cited as a disadvantage, because it was believed that this separation of sites between WIN/SAU and CHRP could lead to a problem in losing track of clients, including rural clients who did not like the inner-city location. It was also felt that the numbers who could be served was too limited because of the necessary use of control groups. The representative from WIN/DOL thought that she could not see much change in clients perhaps because physical health problems were not the only barriers to employability and that the limitation on employability was not altered. She also emphasized that the clients sent to CHRP had "a combination of disabilities plus other problems".

It was generally considered that, if health rehabilitation services were to be provided in the future, treatment should be completed before employment or training was started. Opinions were varied with respect to the priority for employment which would be given to a client who had had a poor work history due to medical problems. Of the six persons responding to this question, one gave a high priority to such clients, two stated that they should be treated like anyone else, and three gave a low priority. Only four persons answered the question as to the priority for employment that they would give to a CHRP client who had had a poor work history due to medical problems, one suggesting that a high priority should be given and three that such a person should be treated like anyone else.

In answer to a question as to whether health intervention by CHRP had increased the employability and job holding capacity of DSS clients taking part in the program, Ithaca respondents expressed an enthusiastic "yes, absolutely;" "yes, people are more self-directing and have more self knowledge." The Syracuse WIN/DOL and SAU were more guarded in their comments, which included: "Yes, for a small number, perhaps 10%;" "Jobs are there; many referred to SSI;" "not that much more because of recession; many referred to SSI."

Responses to a question on the relative advantages or disadvantages of having a health counselor to work with DSS clients on medical rehabilitation for employment were varied with the Ithaca respondents considering that such a counselor might be useful. Comments from the Ithaca respondents included: "would save time and therefore money;" "would save referring people who are not ready to work;" "could provide referral as well as services." Qualified responses were obtained from three Syracuse respondents, including "yes, unless current staff has the ability;" "not WIN because we are supposed to get only the healthy ones, but in another section of DSS;" and "as consultant to staff, because the client has too many different workers." An interesting additional comment by an Ithaca respondent was that "a DSS relationship (of the health counselor) may turn some people off."

C. Survey of WIN Regional Directors

In order to examine the opinions of WIN Regional Directors with respect to health services within the WIN program, a structured questionnaire was designed and administered by telephone interview by the evaluator from January to February, 1978. Nine completed interviews were obtained, and these were taped and transcribed. The following report pertains to the Regional Directors' responses to questions as well as their comments. The identification of respondents has purposely been omitted.

WIN Regional Directors saw a need for uniform health evaluation of clients who claim a health problem as a deterrent to employment. One respondent who did not favor uniform health evaluations felt that physicians would not carry out their duties with the required degree of uniformity. Those who did feel that a uniform health evaluation of WIN clients would be desirable saw a need for physicians to be trained and experienced in employment-related health evaluations. It was also considered as desirable by the Regional Directors that physicians who carry out WIN health evaluations should be oriented to the WIN program by WIN personnel; and one respondent suggested a joint orientation program with VR. Whether health evaluation of AFDC recipients with health problems should be conducted when they are initially seen at IM (IM - Intake), or at WIN registration produced basically two groups of answers, such that four out of the eight WIN Regional Directors who were asked this question preferred the health evaluations to be done at IM-intake, and the four others considered that these evaluations should be available both at IM and at the time of WIN registration, lest client health problems might otherwise be missed. No intent was voiced that two health evaluations should be carried out, but rather that a client who presented with a health problem at the time of WIN registration, and not earlier, could then be evaluated at that point. The location of physicians in relation to DSS or employment service or outside the agency's system was viewed differently by different respondents. Priority was, however, voiced for a system that would be convenient to clients; and one respondent suggested that in some areas, a mobile health unit might be desirable. WIN Directors did see a need for follow-up by the physicians who had carried out the initial health evaluation of WIN clients.

Eight out of the nine respondents favored the provision of a health counselor or health educator as a component of the WIN program, assuming that the Federal WIN program would provide the salary. Those who qualified their answers questioned whether the caseload would justify this appointment. With respect to location of the health counselor, four favored location in Income Maintenance in the Welfare agency, three essentially favored collocation within WIN/SAU. Guidelines on the job level of the health counselor were supplied by four WIN Regional Directors, of whom three favored a health counselor/health educator to be placed at the same staff level as the employment counselor, and one favored a higher level of appointment. Enthusiasm was voiced in response to the question as to whether WIN Directors would be willing to have a health service model as a demonstration project in their Regions. In addition to actual responses to the questionnaire, the WIN Regional Directors were outgoing in their suggestions pertaining to the development of a health service in the WIN system. Verbatim quotations from their comments are appended under specific headings which pertain to the development of the demonstration model. (Responses of WIN Directors appear in the Appendix.)

D. Questionnaire to WIN State and Regional Directors

The respondents whose questionnaire answers are tallied in Table 19 were from Rhode Island, Connecticut, Massachusetts, New Hampshire, Vermont, Maine, Pennsylvania, Indiana, Wyoming, Utah, North and South Dakota, Montana, Colorado, Wisconsin, Ohio Washington, Nevada and California. Six local replies from California were collated and tallied as a single response. Four unmarked, "anonymous" replies were also included.

Table 19. Responses to questionnaire items regarding WIN policy and practices (22 respondents). Questions renumbered.

1. If clients, deemed incapacitated by IM, are rejected by VR, what happens to them?

	No. "Yes" Responses	% "Yes"
a) They are registered by WIN	3	13.6
b) They are not registered by WIN because they are considered to be medically exempt	16	72.7
c) They are registered by WIN and placed in the recipient pool	4	18.2
d) Other policy mentioned	2	9.1

2. If after WIN registration and the appraisal interview, a client referred by IM as "mandatory" is considered to be exempt due to health problems, how is medical determination of health complaints obtained (One or more answers may be checked):

	No. "Yes" Responses	% "Yes"
a) by the client's own family physician	17	77.3
b) by a physician appointed by WIN program	2	9.1
c) by a physician, chosen by the registrant from an approved list	6	27.3
d) by any physician of the registrant's choice	19	86.4
e) by a certified psychologist	11	50.0
f) by a U.S. Public Health Service M.D.	3	13.6
g) other specified	2	9.1

3. If a WIN registrant is determined to have health problems and it is ascertained by the examining M.D. that treatment of these would not interfere with employment or training, would you consider:

	No. "Yes" Responses	% "Yes"
a) that employment training should be concurrent with treatment	11	50.0
b) that treatment should be completed before employment or training	9	40.9

4. What priority for employment would you give to a WIN registrant who had a poor work history due to medical problems?

	No. Respondents	%
High priority	0	0
Treat like anyone else	6	27.3
Low priority	16	72.7

5. Do you have a health counselor in SAU or WIN/DOL units?

No. "No"	%	No. "Yes"	%
22	100	0	0

Table 19a. Responses to questionnaire items regarding evaluation of present WIN policy and recommendations. Questions renumbered, 22 respondents.

1. Do you think that the present methods used by IM to determine medical exemption from WIN registration are satisfactory?

	No. "Yes" Responses	% "Yes"
a) in determination of incapacity	10	45.5
b) in determination of illness (temporary exemption)	11	50.0

2. Can medical verification of health problems of registrants usually be obtained within 30 days?

No. "Yes" Responses	% "Yes"
10	45.5

3. Do you think the present WIN method(s) of medical verification are satisfactory?

No. "Yes" Responses	% "Yes"
12	54.5

4. Do you think that the health determination by IM and WIN could be combined?

No. "Yes" Responses	% "Yes"
12	54.5

5. If a standardized health evaluation procedure were developed, which of the following systems would be preferable in your area? Indicate your first and second preference.

	Mean Rank	No. 1st Pref.	% 1st.	% 2nd.
Colocation of a health unit with SAU	3.25	2	9.1	18.2
Contractural arrangements with local family practice clinic	2.42	5	22.7	36.4
Appointment of approved physicians in the area to carry out health evaluations of registrants or applicants	2.10	11	50.0	18.2
Contractural arrangement with the U.S. Public Health Service Unit	3.54	1	4.5	0.0

6. Do you consider that job related health services should be provided by SAU? 90.9% "Yes" (20/22 respondents).

If yes, which of the following services should be provided:

	No. "Yes" Responses	% of Total Sample
Medical referrals	19	86.4
Psychological counseling	11	50.0
Health education	14	63.6
Other specified	4	18.2

Table 19b. Perceived relative importance of different types of health problems. ("Which of the following health problems detract most from employment of WIN registrants in your Region? Indicate the most and the least frequent; number from 1-6 according to frequency.")

Type of Problem	Mean Rank[a]	No. Ranking First	% 1st.	% 2nd.
Emotional	3.22	4	18.2	18.2
Alcoholism	4.45	0	0.0	4.5
Back/leg problems precluding standing or lifting	2.41	9	40.9	18.2
Obesity	4.07	2	9.1	18.2
Chronic or recurrent physical disease	3.60	4	18.2	9.1
Multiple health complaints--no physical disease	3.26	3	13.6	31.8

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[a] Kendall's coefficient of concordance W = .146, $p < .05$. This corresponds to an average Spearman rank correlation between any two given respondents of .105. This statistic refers to a significant agreement between respondents, not to the accuracy of the rankings per se.

E. Health Educator Questionnaire.

In order to obtain information on professional programs for health educators appropriate to the training needs of the proposed health professional in the WIN demonstration model (health educator/counselor), we sent questionnaires to 43 schools including schools of public health and allied health sciences. Of those questionnaires, 29 were completed and returned.

Analysis of these questionnaires indicates that schools may offer degree programs at the Bachelor's, Master's, or Ph.D. level, but that most schools (27 out of 29) had a Master's degree program. Previous work experience was recommended or required by 11 of these schools. Students are prepared for careers in health administration, hospital administration, public health social work, maternal and child health, public health education (23 out of 29), public health nutrition, community mental health, environmental health sciences, biostatistics, comprehensive health planning, epidemiology and biomedical laboratory sciences.

Salary scales of graduates vary with the level of the degree program. For students obtaining the Master's degree (M.S./M.A./M.P.H.), entry level salary scales range from $10,000 to more than $16,000 with more respondents suggesting that salary scales for Master's degree applicants, on entry into employment, fall into the middle to upper part of this range, e.g. 12 out of 29 respondents indicated entry-level salary for a student who had obtained the M.P.H. as between $12,000 and $16,000.

Field work was cited as part of the program by 18 out of the 29 schools, and 13 indicated that their program included specific course and/or field work which would prepare students to work with welfare clients.

IV. THE DEMONSTRATION MODEL

A. Overview

When seeking to design a health service to be incorporated into the WIN system, we are cognizant of constraints as well as challenges to be met. The desirable ideal is that WIN clients should have no health needs at the time of regular WIN registration. If residual health problems exist at the time of registration, then these should be minimal and should not prevent or limit employment of clients in those occupations for which openings are available. Our experience has shown us that many clients do not fit this description of the ideal WIN client. While one accepted goal of the demonstration model system is to prepare prospective WIN registrants for entry into competitive employment, another goal which should have priority is to rehabilitate more highly disabled persons to an intermediate stage of special placement jobs, that they would then be able at a subsequent date to become WIN registrants under the regular system and could enter competitive jobs. The model has been developed as a consequence of research during the past three years and after discussion of an earlier demonstration model proposal with WIN Directors and key persons in health care delivery systems.

It is proposed that the demonstration model be a pilot to be tested in operating situations, but successful operation of the demonstration model assumes better assurance of employment either in special placement or in competitive jobs when health problems have been addressed than has been true in the past. In other words, if one of the measures of successful outcome of rehabilitation is the number of job placements, then the WIN system must make provision for persons who have achieved fitness for work and this requires emphasis on job development and job placement. In addition to job training and placement, alternate methods of measuring successful outcomes include decrease in size of welfare grants, better disposition of clients with respect to VR and SSI referral, duration of employment after placement and decrease in expenditures under Title XIX. It is further suggested that successful outcome be measured in terms of the number of persons moving from unemployment to special placement and from special placement to regular WIN registration.

B. Target population

Under the model, health assessment would be required of all new cases referred to WIN from Income Maintenance as having eligibility for WIN registration if these persons:

1. show obvious evidence of mental or physical health problem(s) e.g. obesity
2. show signs of alcohol or drug abuse
3. have a recent history of mental or physical illness
4. state that health restricts work
5. state that they are currently in diagnosis or under treatment other than temporary illness

6. lost most recent job for health reason
7. are suspected of hypochondriasis by IM Intake worker and/or
8. are multi-problem cases with history/current health and social problems.

New cases would receive priority for health assessment, but health assessment would also be undertaken for WIN volunteers and also for persons in the unassigned recipient pool if they complained of health problems, had lost their most recent employment for health reasons or fall into other problem health categories listed above. In recommending that WIN volunteers be included in the target population, we particularly consider the desirability of including mothers or other caretakers with a child under the age of 6 and mothers or other female caretakers of children when the nonexempt father or other nonexempt adult male relative in the home is registered and has not refused to participate in the program or to accept employment without good cause.

Data from our recent field study has shown that women in younger age groups even though they may have young children are a target group which can be successful in training and employment. This group makes up a large proportion of those who are currently WIN volunteers. Although the percentage of WIN volunteers was 20.8 percent nationally as of September, 1977, the percentages vary by state and region and in some states, range from a third to about a half of the total WIN registrants. As one regional director stated as their reason for volunteering, "They want to work. Welfare is not their ultimate aim in life. They have aspirations like anyone else and so they try to maximize what opportunities are given. So there is incentive within the AFDC population."

If family health problems are cited by WIN registrants as barriers to employment or rehabilitation, then the sick or handicapped persons within the family would be screened with respect to their health and referred to appropriate health care agencies for treatment.

C. Modes of delivery and staffing patterns

The demonstration model should include two components including health assessment and health services. The preferred point of intake would be WIN/SAU in the initial demonstration model system though in circumstances where IM and WIN/SAU are collocated, health screening might be developed at the point of initial contact of the client with the Income Maintenance (IM) unit.

In the preferred means of health care delivery within the WIN system, freedom of choice of the client with respect to their choice of physician to undertake health assessment would be maintained insofar that each client requiring health assessment would first be given an opportunity to obtain the necessary assessment from their own MD. If the client failed to obtain the necessary health assessment, supported by a report within 30 days, then an MD or medical nurse practitioner assigned by WIN to carry out such health assessment would be provided.

In either case, the cost of the health assessment would be accepted by WIN. All physicians or nurse practitioners who would carry out health assessments for WIN clients would be expected to complete forms documenting health problems found and whether these be of a physical or mental health nature. In addition, the physician or nurse practitioner would be asked to complete questionnaires with respect to health reasons which might limit the client's employability or success in job training. The medical report and completed questionnaire together would then provide WIN with an objective measure of the client's total health status and standing with respect to employment. If a client failed to obtain a health determination (either an assessment from their own MD or from the WIN MD or nurse practitioner), then they would be sanctioned. It is suggested, however, that if they obtained a health assessment from any of these sources and a health problem be documented, then as a reward, they might obtain special placement.

It is our intent that a health counselor/educator be the key health person in the newly developed WIN health system. Following the return of the health assessment report of clients to WIN, client case reviews will be held with the WIN employment counselor, WIN/SAU social worker and the health counselor being present. At that time, decisions with respect to client disposition would be made. Clients having no health problems found during health assessment would be referred for regular WIN registration. Those having severe permanent health handicaps would be referred to VR or SSI. Those found to have remediable health problems or health problems which might benefit from treatment would be made temporarily or permanently exempt from regular WIN registration and placed in the special programs' category. The special programs' category of WIN would also receive VR rejects.

When a new client or a client from the unassigned recipient pool would be put into the special programs' category, then they would be eligible for health services and for special employment placement (WIN). Special employment placements would be concurrent with health intervention if this were considered desirable.

Health services would include health counselling and education and/or medical referral and/or referral to health support services such as weight reduction programs, alcoholism programs, or drug abuse programs. Whenever payment for health services were required, this would be covered by Title XIX since clients with one or more diagnosed health problems are eligible for assistance. When special health services were required through the provision of prostheses or special surgery, prior approval of Title XIX personnel would be obtained.

Special employment placement would be mainly in public service employment but might be in the private sector. Such employment would be related to health factors, to job skills and to personal factors.

When health problems that are related to employability are resolved, the client would then be expected to become a regular WIN registrant. Only those clients who were found to have major problems precluding early placement would be referred to the unassigned recipient pool.

Two options are being considered with respect to the staffing of the WIN health service. In the first option which we have considered, the key person would be a health evaluator who could both undertake health assessment and provide health services such as health counselling, health education and play an advocate role in medical referral. In the event that the WIN program chosen for the demonstration model were of moderate size, the health evaluator could be the sole health person and it is thought desirable that this person should be able to fulfill the several roles described above. However, an indepth examination of training programs for health counselors and educators suggests that these persons seldom have the training or expertise as nurse practitioners so that they would be unable to carry out health assessment. The second option offering several practical advantages is that the health evaluator, who might be an MD or a medical nurse practitioner, would be additional to a health counselor/educator. The health evaluator (MD or nurse practitioner), who would be responsible for the initial health assessments as well as defined follow-up, would be located outside the WIN unit in a local primary health care clinic though collocation in the same building cannot be excluded if there is a pre-existent health care unit in the building where WIN/SAU is situated. The health counselor/educator would be located within the WIN facility. In establishing one or more demonstration models, the necessity of comparing the new system as described above with the classical model is upheld. The flow diagram describing the operation of the demonstration model follows the section entitled "Process".

D. Staff training and tasks

1) Training and tasks of health personnel

a) Health educator/health counselor.

This person must have had formal training to the master's degree level in health counselling and health education emphasizing strategies to promote voluntary behaviorable change in health attitudes within the target group. Experience in working with community health agencies and a knowledge of the total health care delivery system would be essential.

Responsibilities of the health counselor/educator would include administration and program development with implementation. It is projected that 15 percent of the person's time would be spent on administration and 85 percent of the person's time on program responsibilities. Administration would include record keeping and program evaluation. The programatic aspects of the health educator/counselor responsibilities would include client health screening and referrals for health evaluation, health intervention, referral to area health support services and follow-up. In addition, duties would include the training of the local WIN staff to acquaint them with the aims and process of the client's health screening and intervention. Liaison between WIN and health agencies would be initiated and maintained by the health counselor.

b) Physician/medical nurse practitioner.

It is necessary that the health evaluation be performed by a physician or nurse practitioner who has the necessary training and expertise. While we use the term physician and nurse practitioner interchangeably, it is our recommendation that nurse practitioners be considered as the primary source for standardized health evaluations. This recommendation is supported by information from health professionals as well as by information from WIN directors, familiar not only with WIN but with VR physical examinations. The training of nurse practitioners presently develops expertise in working to protocol and therefore they are more likely than a physician to follow a standardized health evaluation procedure. If the nurse practitioner were assigned to carry out health evaluations on WIN clients, then it is assumed that this health professional would be responsible to an MD in a health care unit. In any case, diagnostic responsibility would rest with the MD.

Family practice training programs for physicians and also training programs for nurse practitioners are now widely available and it is proposed that physicians and/or nurse practitioners who have completed training and have gained specific expertise in the evaluation of work-related health disabilities could conduct standardized health evaluations of clients for the WIN program. Training of physicians and nurse practitioners who could function effectively in the health evaluation of clients within the system, would require the establishment of a training module which could either be an integral part of their medical education or could be as a practicum in continuing medical education for persons already out of school. Training requirements for physicians and nurse practitioners who operate in the WIN (or other Manpower programs) with respect to health evaluations must include the following components:

1. Instructional seminars on the requirements of specific occupations, with such seminars supplemented by site visits to places of work including factories in order to learn about tasks which have to be performed by operatives or other workers;
2. Instruction in the objective evaluation of work disabilities including observational or practical experience in an industrial health setting;
3. Counselling skills on job-related health problems obtained from use of audio-visual materials including movies, slides and tapes;
4. Field trips to alcohol and drug abuse units and rehabilitation centers;
5. Instruction given by counselors and/or administrators from the WIN program on aims, procedures, and interagency liaison;
6. Training with regard to eligibility criteria for WIN, VR, SSI and CETA; and,
7. Instruction in the use of objective measures to provide uniformity in health evaluations and in faithful reporting of findings with respect to health problems and disabilities with specific reference to job limitations.

The focus of health evaluations by the nurse practitioner or physician would be to determine work-related health problems so as to meet the needs of the WIN system.

E. Location of staff and administrative pattern

In discussions with WIN staff and Department of Social Services and State Employment Service personnel, a number voiced their opinion that it would be convenient and timesaving to have the examining physician or nurse practitioner collocated with either WIN/SAU or WIN/DOL. However, discussion with health personnel, who were familiar with such health evaluation procedures, as well as with others of the WIN staffs, produced another point of view. Their opinions were that such locations, though convenient for clients who could be referred "right down the hall", would be time-consuming for health professionals and might in the long run lead to second rate medicine because such work might not attract the best physicians or nurse practitioners. It is our recommendation that unless a health unit already exists in the same building as WIN/SAU, that the trained nurse practitioner or physician be located in free-standing ambulatory primary care units or in such units attached to hospitals or public health departments. Such ambulatory primary care units are widespread throughout the United States. We highly recommend that the clinics (primary ambulatory care units) which are selected for standardized health evaluations be located in the same locale as the predominant number of prospective clients, thus obviating problems relating to client transportation and keeping of appointments.

A contractual arrangement between WIN (WIN/SAU) and the primary health care unit would be established, wherein persons in the target groups and on AFDC who report health or disability problems would have a comprehensive and standardized health evaluation carried out by the trained nurse practitioner or physician. The cost of the standardized health evaluation whether carried out by the client's own physician or by the health provider under contract as described above would be accepted by WIN.

The health counselor/health educator would be located at WIN/SAU and would be administratively responsible to the WIN Director. Since we project that there would be a need for the health counselor/educator to provide consultant services to IMU with respect to the health of applicants for AFDC assistance, it is considered desirable that the health counselor/educator should apportion her/his working time so that she/he could be available for a limited amount of time in the IM unit.

Current WIN regulations require that the IM staff determine which applicants for AFDC assistance payments are required to register with the WIN sponsor as a condition for eligibility for AFDC. All of the regional WIN directors who were surveyed by us stated that health evaluations should be done at the Income Maintenance level with half indicating there was also the necessity in some cases for such evaluations at the WIN/SAU level. Our initial preferred choice for the location of the health educator/counselor was at both the IM and the WIN/SAU levels. While this choice was supported by most of the data that we obtained, a regional Federal representative for WIN/HEW indicated strongly that whereas he thought this had considerable potential, it was necessary first to discover whether the demonstration model could be completely within the WIN system. We have been guided by his advice in our recommendation that the health counselor/educator should be administratively responsible to WIN/SAU.

F. Process*

1) Initial health screening

At the point of entry or re-evaluation for public assistance, the overall target population defined in the section,"target population", would be asked to complete a form with respect to their current health situation including complaints, presenting health problems, perceived limitation or capacity for work and health reasons for loss of employment of the most recent job. These screening forms would be administered by the intake workers, trained by the health counselor/educator in the use and the interpretation of these forms. Persons in the target population who will be referred to WIN/SAU, except for WIN volunteers, must meet eligibility criteria for WIN registration. All persons within the target population documenting health problems on these screening forms would be referred by the health counselor/educator for a health evaluation either by their own physician or by the assigned nurse practitioner/physician selected to carry out such examinations for WIN. The health counselor/educator would be available to the IM intake worker for assistance in evaluation of the appropriateness of the referral.

2) Health evaluation

Clients within the target population requiring health evaluation shall either be referred to their own physician (physician of their choice) or shall be referred to the assigned nurse practitioner/physician. The health evaluation will consist of a medical history, physical examination, mental health screening (including Beta score and MMPI hypochondriasis score). The M.D. or nurse practitioner either of the client's choice or assigned shall then complete forms documenting the presence or absence of one or more specific health problems, work-related health disabilities and proposed client disposition. If the N.P. or M.D. find abnormalities on physical or mental examination which require workup or further tests to determine a diagnosis, referral may be made for diagnostic purposes and completion of the health evaluation. It is proposed that the reporting form be a problem-oriented medical record,which would be pretested and codes developed for precoding of the final forms.(31)It is assumed that a copy of these records will be made available to the health counselor/educator following the written consent of individual clients. Such medical records will be kept by the health counselor in confidential files. The full medical record will not be made available to other agency personnel; however, copies of the face sheet may be detached and discussed in subsequent case conferences.

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*The Model WIN Health Component diagram and client record forms appear at the end of this section.

3) Case conference

A case conference shall follow the health evaluation attended by the health counselor/educator as well as the employment counselor and the WIN/SAU social worker. It is further desirable that, whenever possible, the nurse practitioner or assigned physician should be present at these case reviews. This client conference is for the purpose of decision making on client disposition. Clients having no health problems found during health assessment would be referred for regular WIN registration. Those having severe, permanent health handicaps would be referred to VR or to SSI. Those found to have remediable health problems or health problems which might benefit from treatment would be made temporarily or permanently exempt from regular WIN registration and placed in the special programs category. The special programs category of WIN would also receive VR rejects. It is recommended that a VR and SSI representative be present at the case conference for those having severe, permanent health handicaps. In the event that persons in the target population have escaped IM health screening and are currently under the care of a physician or surgeon, supportive evidence must be presented at these case reviews to indicate when recovery will allow regular WIN registration.

4) Special programs

As indicated above, when a new client or client from the unassigned recipient pool is placed in the special programs category, they would be eligible for health services and for special employment placement (WIN). Special employment placement would be concurrent with health intervention if this is considered desirable. Those persons placed in the special programs category would be deferred from regular WIN registration.

5) Health intervention

In all cases, the clients shall be fully acquainted orally and in writing by the health counselor/educator with the salient features of their health evaluation and decisions with respect to their immediate WIN registration or their proposed placement in the special programs category. Medical and dental services will be obtained for clients by the health counselor/educator as indicated for diagnostic purposes and in the proposed intervention plan. Further, as required, the health counselor/educator will act as advocate for the client in obtaining health support services, such as entry into weight control programs, attendance at speech/hearing clinics, and/or referral to area nutrition support services.

Rehabilitation services to be provided directly by the health counselor shall include health education and counseling. Key areas of the health education program are those which need attention in order to fit the client for employment. These are identified as follows:

1. hygiene
2. eating and drinking practices
3. smoking
4. use of medical and dental services

5. compliance with prescribed medical therapy
6. drug usage
7. exercise
8. self-induced illness
9. preventive health care
10. health maintenance in the job/job training environment.

Whenever local health and nutrition support services are available and client need and eligibility for such services has been ascertained, the health counselor shall make appropriate referrals and assist clients to utilize such services. Local support services which will be used as resource units for referral of clients by the health counselor include:

1. alcoholism and drug abuse units
2. EFNEP (USDA Cooperative Extension Expanded Food and Nutrition Education Project)
3. WIC
4. family planning clinics
5. community weight control programs
6. speech/hearing clinics
7. mental health clinics

The health counselor would make medical/surgical and dental appointments for clients to effect prompt treatment of health problems which have been defined as work limitations at the time of health evaluation. Prior approval for such appointments should be obtained from the Medicaid office. It is assumed that the cost of services would be accepted under Title XIX.

6) Client follow-up

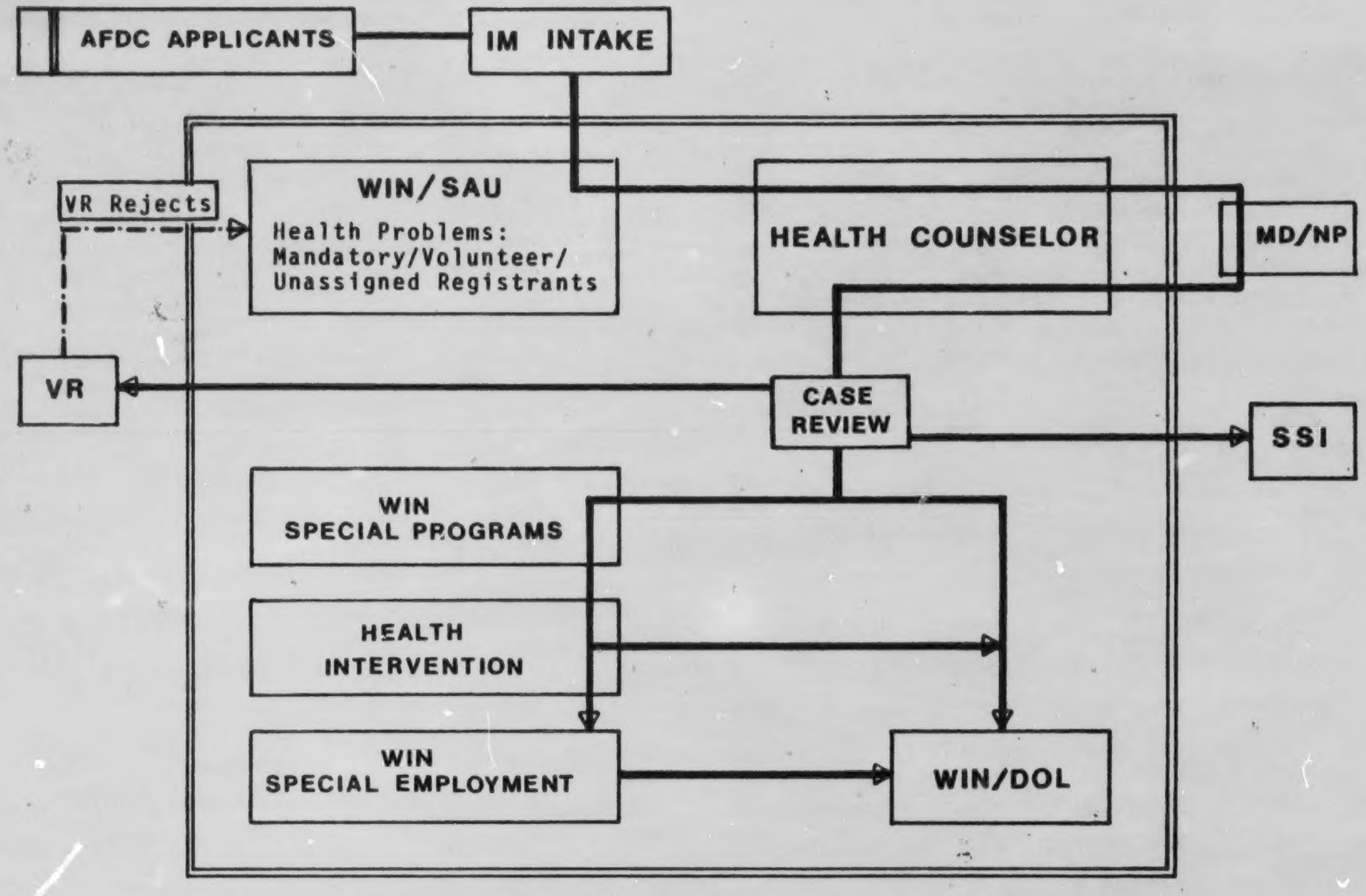
The health counselor would maintain contact with clients during the period of health rehabilitation recording progress, when health problems become inactive, time of special employment placement, compliance or otherwise with medical and dental appointments, and need for follow-up by the assigned nurse practitioner or physician. The health counselor would also keep records of the client's household or work-related problems as these may enter into the decision making process with respect to client disposition. Timing of placement of the client in special employment placement should be the joint decision of the WIN counselors and the health counselor. When health problems affecting employability have been resolved, then the client should be returned to WIN/SAU for regular WIN registration.

G. Implementation of the demonstration model

1) Proposed location

It is proposed that the demonstration model be tested in HEW Region IX, given that Federal, State and County approval is obtained. In Region IX, 2 counties will be selected, each having 2 or 3 WIN units. From discussion with WIN administrators, other possible locations for the demonstration model would be Region VIII or Region IV. One advantage of Region IV would be the opportunity to study the impact of the proposed model on WIN volunteers because of the high proportion of such in this region.

Figure 3


AFDC APPLICANTS
IM INTAKE
VR Rejects
WIN/SAU
Health Problems:
Mandatory/Volunteer/
Unassigned Registrants
HEALTH COUNSELOR
MD/NP
VR
CASE
REVIEW
SSI
WIN
SPECIAL PROGRAMS
HEALTH
INTERVENTION
WIN
SPECIAL EMPLOYMENT
WIN/DOL

Model WIN Health Component

EMPLOYMENT-RELATED PROBLEM-ORIENTED MEDICAL RECORD

NAME	ID	AGE	DATE OF BIRTH	ADDRESS	TELEPHONE NO.	MARITAL STATUS	NO. CHILDREN	NO. CHILDREN UNDER 6 YEARS	MEDICAID NO.

CHIEF COMPLAINT

REASON FOR COMING TO CLINIC

HISTORY OF ACTIVE PROBLEM
DURATION:
SYSTEM OR PARTS AFFECTED:
CLIENT'S STATEMENT OF PROBLEM:

HEALTH-RELATED REASON FOR NOT WORKING	HEALTH REASON FOR LEAVING LAST JOB
1	
2	
3	

HEALTH MAINTENANCE INFORMATION (WITH DATE)

RESOLVED ILLNESSES
OPERATIONS
HOSPITALIZATIONS
TRAUMA

	PURPOSE	GENERIC/ PROPRIETARY NAME	DOSE	FREQUENCY	DURATION
MEDICATIONS (CURRENT R_X					
OTC)					

Chart 1

TOBACCO: NO. PACKS OF CIGARETTES/DAY ______
ALCOHOL: QUANTITY_____ FREQUENCY_____ DURATION_____
COFFEE: QUANTITY_____ FREQUENCY_____ DURATION_____
OTHER DRUGS: QUANTITY_____ FREQUENCY_____ DURATION_____
ALLERGIES: YES____ NO____
USE OF SEAT BELTS IN AUTO: YES___ NO___

HEALTH REHABILITATION AGENCY CONTACTS (WITHIN THE LAST YEAR)

	DATES	PLACE
VR		
VA		
WORKMAN'S COMP.		
SSI		
ALCOHOL ABUSE		
DRUG ABUSE		
OTHER HEALTH RELATED AGENCIES (PLEASE SPECIFY)		

HOUSEHOLD HEALTH HISTORY (HEALTH PROBLEMS)

	AGE	PHYSICAL	MENTAL/PSYCH	REQUIRES SUPERVISION
SPOUSE				
CHILDREN				
OTHER HOUSEHOLD MEMBERS				

REVIEW OF SYSTEMS (OTHER THAN RELATED TO FIRST COMPLAINT)(INDICATE 0 or ✓)

HEAD: __HEADACHES __HEAD INJURY

EYES: __VISION LOSS __DIPLOPIA __PAIN __REDNESS __GLAUCOMA

EARS: __HEARING LOSS __EARACHE __DISCHARGE __TINNITUS __VERTIGO

NOSE: __OBSTRUCTION __DISCHARGE __SNEEZING __HAY FEVER __NOSE BLEEDS __SINUSITIS

MOUTH: __SORE MOUTH __SORE TONGUE __DENTAL CARIES __BLEEDING GUMS __SORE THROATS

NECK: __HOARSENESS __DYSPHAGIA __GOITER __LUMPS OR NODES __PAIN

LUNGS: __WHEEZING __COUGH __SPUTUM __HEMOPTYSIS __BRONCHITIS __PNEUMONIA __PLEURISY __ASTHMA __TB __LAST CHEST XRAY?______

HEART: __SHORTNESS OF BREATH __ORTHOPNEA __PAR. NOC. DYSPNEA __CHEST PAIN __PALPITATIONS __EDEMA __RHEUMATIC FEVER __HEART MURMURS __HIGH BLOOD PRESSURE __HEART ATTACK

BREASTS: __(F) LUMPS IN BREAST __DISCHARGE FROM NIPPLES

GI: __ANOREXIA __NAUSEA __VOMITING __CONSTIPATION __DIARRHEA __PAIN __BLEEDING __JAUNDICE __ULCER __GALL BLADDER DISEASE

GU: __FREQUENCY __POLYURIA __NOCTURIA __DYSURIA __HEMATURIA __DIFFICULTY STARTING OR STOPPING URINARY STREAM __INCONTINENCE __URINARY TRACT INFECTIONS __STONES __HERNIAS __SYPHILIS OR GONORRHEA __SURGERY

FEMALE MENSES: FREQUENCY ____ DURATION ____
AMOUNT OF FLOW______ PAIN______ INTERMENSTRUAL BLEEDING ______ VAGINAL DISCHARGE _____ ITCHING _____

MENOPAUSE: __ SURGERY __NATURAL CAUSES

OBSTETRICAL: NO. OF PREGNANCIES__ NO. OF DELIVERIES__
NO. OF LIVING CHILDREN__ OBSTETRICAL COMPLICATIONS__

MALE: __SCROTAL MASS __EDEMA __TENDERNESS __EPIDIDYMUS __PENILE LESION __DISCHARGE __SURGERY

MUSCULO-SKELETAL: __PAIN __STIFFNESS __SWELLING OF JOINTS __BACK PAIN __ARTHRITIS

NEUROLOGICAL: __SEIZURES __FAINTS __WEAKNESS OR PARALYSIS __TREMOR __LOSS OF SENSATION __NUMBNESS __TINGLING

SKIN: __RASHES __NODULES __SORES __CHANGE OF TEXTORE OR COLOR __LOSS OF HAIR

PERIPHERAL VASCULAR: __VARICOSE VEINS __PHLEBITIS PERIPHERAL PULSES (FEET) R__ L__

BLOOD: __ANEMIA __BLEEDING TENDENCIES __TRANSFUSIONS

ENDOCRINE: __DIABETES OR ITS SYMPTOMS __THYROID TROUBLE OR SYMPTOMS __RECENT WEIGHT CHANGE: __GAIN __LOSS

Chart 2

EMPLOYMENT-RELATED PROBLEM-ORIENTED MEDICAL RECORD

NAME ID AGE ADDRESS TELEPHONE NO. MARITAL STATUS MEDICAID NO.

PHYSICAL EXAMINATION:

HEIGHT______ WEIGHT______ TRICEPS SKINFOLD______

BP______ PULSE______ RESP:______ TEMP________

1. SKIN: (a) acne (b) dermatitis (c) icterus (d) impetigo (e) other rash (f) scars (g) nail changes (h) rosacea (i) discoloration: brown, yellow (j) needle tracks (k) insect bites (l) dirty (m) varicose veins: present, absent
2. SCALP: (a) normal (b) tenderness (c) alopecia (d) infestation
3. LYMPH NODES: (a) present (b) absent (c) location ______________.
4. EARS: (pinna, external canal, tympanic membrane) (a) normal (b) discharge (c)
5. NOSE: (septum, sinus) (a) normal (b) tenderness (c) obstruction (d) discharge (e)
6. THROAT & MOUTH: (lips, tonsils, buccal mucosa, tongue, pharynx, teeth, gums) (a) normal (b) abnormal
7. NECK: (thyroid, trachea) (a) normal (b) mass (c) other__________.
8. CHEST & LUNGS: Inspection: (a) normal (b) abnormal
   Auscultation: (a) normal (b) abnormal
   Breast: discharge from nipples ________
   Mass R____ L____
9. HEART: Auscultation: (a) normal (b) abnormal
10. SPINE: (a) normal (b) lordosis (c) kyphosis (d) scoliosis
11. ABDOMEN: (liver, spleen, kidneys, stomach, appendix, intestines)
    Inspection: (a) flat (b) distended (c) scaphoid (d) scars (e) other:________________________________
    Palpation: (a) normal (b) rigid (c) tender (d) mass (e) rebound (f) fluid wave (g) hernia (h) liver enlargement
12. GENITALIA: Male: (a) normal (b) scrotal mass (c) edema (d) tenderness (e) epididymus (f) penile lesion (g) discharge (h) evidence of surgery (i) other:___________
    Female: (a) normal (b) edema (c) tenderness (d) discharge (e) pelvic exam (f) other:________________.
13. MUSCULOSKELETAL:
    NECK: (a) normal (b) pain in range of motor (c) limited rotation (d) limited flexion (e) limited extension (f) deformity
    SPINE: (a) normal (b) excess lordosis (c) kyphosis (d) scoliosis (e) limited motion (f) pain with motion (g) decreased reflexes (h) sensory change (i) increased weakness (j) + Leseque's
    SHOULDER: (a) normal (b) limited range of motion (c) pain throughout range of motion (d) pain and limited range of motion (e) atrophy
    ELBOW: (a) normal (b) limited (c) pain with motion (d) deformity
    WRIST: (a) normal (b) limited range of motion (c) pain with motion
    HAND: (a) normal (b) limited in flexion (c) limited in extension (d) limited in rotation (e) pain in flexion (f) pain in extension (g) pain in rotation
    HIP: (a) normal (b) limited in flexion (c) limited in extension (d) limited in rotation (e) pain in flexion (f) pain in extension (g) pain in rotation
    KNEE: Range of motion: (a) normal (b) limited in flexion or extension (c) limited in flexion and extension (d) less than 90° (e) crepitation (f) pain with motion (g) surgery
    ANKLE: (a) normal (b) limited range of motion (c) pain
    FEET: (a) pes cavus (b) normal (c) splay (d) flat (pes planus) (e) pronated
14. PROSTHESIS: NO__ YES__ (specify)________________________ ______

LABORATORY EXAMINATION

	DONE	NOT DONE
CBC		
PAP SMEAR		
STOOL		
URINALYSIS		
SGOT		
SGPT		
SEROLOGICAL TEST FOR SYPHILIS		
TB SKIN TEST		
OTHER - ABNORMAL VALUES		

ANCILLARY DIAGNOSTIC TESTS

CHEST RADIOGRAPH

EKG

AUDIOMETRY

REFRACTION OR OTHER EYE EXAMINATION

SICKLE CELL

SPIROMETRY

EMPLOYMENT-RELATED PROBLEM-ORIENTED MEDICAL RECORD

NAME	ID	AGE	DATE OF BIRTH	ADDRESS	TELEPHONE NO.	MARITAL STATUS	NO. CHILDREN	NO. CHILDREN UNDER 6 YEARS	MEDICAID NO.

Chart 3

PHYSICAL PERFORMANCE TESTS

HANDGRIP DYNAMOMETER: ______

BENDING: - PALMS TO FLOOR:
(a) > 10 inches from floor ____
(b) < 10 inches from floor ____
(c) Tips to floor ____
(d) Fingers to floor ____
(e) Palms to floor ____

PUSHING: ______
PULLING: ______
LIFTING: ______

VITAL CAPACITY: ______
HARVARD STEP TEST: ______
FINE MOTOR ABILITY: ______
SNELLEN CHART WITH GLASSES Left ____ Right ____
" " WITHOUT GLASSES Left ____ Right ____
HEARING TEST Left ____ Right ____

PSYCHOMETRIC TESTS

(If not given, specify reason)*

HYPOCHONDRIASIS SCORE: ____

I - E SCORE: ____

16 PF FACTORS: A ____ F ____ L ____ Q_1 ____
B ____ G ____ M ____ Q_2 ____
C ____ H ____ N ____ Q_3 ____
E ____ I ____ O ____ Q_4 ____

REVISED BETA IQ SCORE: ____

*CANNOT COMPLETE BECAUSE OF:
READING DIFFICULTY - A
WRITING DIFFICULTY - B
INEBRIATION - C
MENTAL CONFUSION - D
OTHER (STATE)

Chart 4

EMPLOYMENT-RELATED PROBLEM-ORIENTED MEDICAL RECORD

NAME	ID	AGE	DATE OF BIRTH	ADDRESS	TELEPHONE NO.	MARITAL STATUS	NO. CHILDREN	NO. CHILDREN UNDER 6 YEARS	MEDICAID NO.

KIND OF HEALTH PROBLEMS (INCLUDING ACTIVE FAMILY ILLNESS)

PROBLEM	EFFECT ON EMPLOYABILITY
1.	
2.	
3.	
4.	
5.	
6.	

PROBLEM INTERVENTION PLAN

PROBLEM	REFERRAL DIAGNOSTIC THERAPY	SUPPORT SERVICE	COUNSELING	HEALTH EDUCATION
1.				
2.				
3.				
4.				
5.				
6.				

GOALS FOR EMPLOYMENT

PROJECTED DATE OF WORK READINESS: ____________

1. SPECIAL EMPLOYMENT _____
2. REGULAR EMPLOYMENT _____
3. JOB TRAINING _____

HEALTH RELATED WORK RESTRICTIONS:

1. ENVIRONMENTAL _____
2. PHYSICAL _____
3. PSYCHOLOGICAL _____

GOALS FOR INTERVENTION

For example:

1. 30 lb. weight loss in 6 mos.
2. Provision of dentures
3. Reduction of sick role behavior

Chart 5

EMPLOYMENT-RELATED PROBLEM-ORIENTED MEDICAL RECORD

NAME	ID	AGE	DATE OF BIRTH	ADDRESS	TELEPHONE NO.	MARITAL STATUS	NO. CHILDREN	NO. CHILDREN UNDER 6 YEARS	MEDICAID NO.

CLIENT PROGRESS CHART

CHANGE IN HEALTH PROBLEM OVER TIME			INTERVENTION				
ACTIVE (DATE)		INACTIVE (DATE)	TYPE	APPOINTMENT	DATE	CLIENT'S COMPLIANCE	SERVICE
For example:			For example:				
3/1	1 obesity						
	2 edentulous		Dental	DDS Jones	3/16	attended	dentures fitted
	3 hypochondriasis						
4/1	1 obesity						
	2 -	wearing dentures					
	3 hypochondriasis						

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2) Client population

While in the preferred Region (IX) groups are heterogeneous, the mixture of ethnic groups is similar for WIN units within counties. This means that variations of the demonstration model can be compared with the classical model (present system). It is projected that each of 3 units within the demonstration model system would evaluate approximately 500 clients per annum. In the total model there would be approximately 2,500 clients, of whom 1,500 would be in the demonstration unit system and 1,000 in the classical system (no special provision in this system for health evaluation or services except as at present).

Since our study has shown that younger persons and particularly young women, including those with young children, are more likely to respond to health counseling and to become employed soon thereafter, in the demonstration model, special incentive should be given to persons under 30 and female to accept the "health package," viz. the initial health evaluation by the assigned health evaluator and the health services given by the health counselor. We assume here that the present WIN measures of success will be applied. The incentive measure which we would like to see used would be priority for young females both in special placement services and in regular WIN job slots.

3) Variations in the demonstration model

On the assumption that 5 WIN units would be included, we propose that 2 of these remain as examples of the classical model without addition of health personnel (Units 2 and 4). Among the other 3 WIN units, Unit 1 would have a health counselor/educator and also would make a contract with the local family practice clinic or other health care unit to arrange for a nurse practitioner or nurse clinician to be assigned as health evaluator to the WIN unit. As described above, the health evaluator would be responsible for the health assessment of all referred clients and for proposing means of intervention and client disposition with respect to health and work. Unit 3 would differ in staffing from Unit 1 in that an M.D. would play the same role as the nurse practitioner in Unit 1. In Unit 5, the nurse practitioner would assume roles both as a health evaluator and as a health counselor. In order for this to be made feasible in terms of numbers of clients and overall work load, (s)he should be assisted by a community health worker (training of community health workers is described in the publication Training Community Health Workers (32). Duties of the community health worker would include home visits, health education of clients under the direction of the nurse practitioner, transport of clients to medical or dental appointments, assistance of clients in obtaining health support services, overseeing of client compliance with treatment plans as well as assistance to the nurse practitioner in routine matters pertaining to the health evaluation process.

If only one demonstration unit, or 1 type of staffing is to be implemented, we prefer the type described as Unit 1 (Table 49).

4) Estimation of costs

Estimation of costs is broken down in Table 50 to include personnel, client costs, evaluation costs and training costs. Costs are projected

Table 49. Variations in WIN demonstration model.

Unit # [a]	Unit Type	Health person in WIN/SAU	Health evaluator in health care unit	Locality
1	Demonstration	Health Counselor	Nurse Practitioner	A
2	Classical	-	-	
3	Demonstration	Health Counselor	M.D.	
4	Classical	-	-	B
5	Demonstration	Nurse Practitioner/Health Counselor Community Health Worker	-	

[a] Random assignment of WIN units as demonstration or classical is acceptable.

to cover a 3-year program such that new clients would come into the demonstration model system only during the first two years. In the third year, since no further clients would be brought into the project, client costs would decrease with elimination of the need for initial health evaluations. Additional costs in the third year would pertain to a training program for health counselors, nurse practitioners and community health workers on a workshop basis (one workshop is proposed) as well as costs of evaluation and data analysis. Whereas a large reduction in costs could be obtained by reducing the number of variations on the demonstration model that are to be tried, the budget given is structured to the design of the full and limited demonstration model systems as described above. The first estimation of costs is based on the assumption that at each of the 3 units where variations of the demonstration model are set up, 500 persons would be seen and given health evaluations during each of the first 2 years of the program. The second estimation of costs reflects use of one demonstration model unit receiving 500 clients for each of two consecutive years (Table 50).

Table 50 . Estimated proposed budget (maximum, minimum) for three-year demonstration model project.

MAXIMUM BUDGET		YEAR	
	one	two	three
PERSONNEL			
Health counselors (2)	$28,000	$28,000	$28,000
Nurse practitioner/health counselor (1)	15,000	15,000	15,000
Community health worker (1)	10,000	10,000	10,000
CLIENT COSTS			
Health examinations by MD (500 @ $15.00 each)	7,500	7,500	0
Health examinations by NP (500 @ $12.00 each)	6,000	6,000	0
Transportation	15,000	15,000	15,000
Communications	3,000	3,000	1,500
Supplies	3,000	3,000	1,500
EVALUATION COSTS			
Project director (summer salary, 2/12)	3,000	3,000	3,000
Transportation (10 round trips/annum)	3,000	3,000	3,000
Per diem (20 days @ $50.00/day)	1,000	1,000	1,000
Communications	1,500	1,500	1,500
Computer services	3,000	3,000	3,000
Validation costs	3,000	0	0
Program evaluator (25% time)	5,000	5,000	5,000
TRAINING COSTS (Workshop)	0	0	12,500
TOTAL BUDGET:	$107,000	$104,000	$100,000
MINIMUM BUDGET			
PERSONNEL			
Health counselor (1)	14,000	14,000	14,000
CLIENT COSTS			
Health examination (500 @ $12.00 each)	6,000	6,000	0
Transportation	5,000	5,000	5,000
Communications	1,000	1,000	1,000
Supplies	1,000	1,000	500
EVALUATION COSTS			
Project director (summer salary)	3,000	3,000	3,000
Transportation	3,000	3,000	3,000
Communications	1,000	1,000	1,000
Per diem costs	5,000	5,000	5,000
Computer services	2,000	2,000	2,000
Validation costs	3,000	0	0
TRAINING COSTS (Workshop)	0	0	12,500
TOTAL BUDGET:	$ 44,000	$41,000	$47,000

5) Administrative arrangements

Administrative arrangements would start with the Department of Labor, Washington, then WIN at the Regional level, then at the State level, then at the local level. Project development and evaluation would be by the project director and evaluator based at Cornell University. As mentioned above, the health counselor would be responsible to the local WIN director. The nurse practitioner would be responsible to the M.D. in the health care unit. In variation 5, (s)he would also be administratively responsible to WIN at the local level.

a) Job descriptions.

i) Health counselor/educator

The WIN program Regional office invites applications from individuals qualified as health educators or counselors with particular strength in educational techniques which may influence health practices and health status of welfare recipients. Experience of alternate modes of health delivery and health screening methods is also essential. Candidates should hold an M.P.H. degree from a school of public health, or an equivalent master's degree from a school of allied health sciences, and be graduates of a specialized program in community health education. Responsibilities will include development and application of a health screening program to define health problems in WIN registrants and also provision of ongoing health counseling services for these persons. Applicants should send curriculum vitae and names of three references to (name and address to be specified).

ii) Nurse practitioner/coordinator

Exciting new position for nurse practitioner to develop health services for the WIN program. Responsibilities will include health screening and health education for welfare clients. Educational background should include RN and MSN or MPH. Preference will be given for applicants with training and experience in health education. Administrative skills essential.

iii) Community health worker

Employment program requires community health worker to offer health education to welfare clients and to act as medical assistant in a health screening program. Applicants should have had training as a community health worker and experience in working with poverty groups.

iv) Justification for projected staffing pattern

CHRP experience with the contribution of staff members to the operation indicated that the key staff were those involved with health evaluation and those involved with health rehabilitation.

Whereas physicians played a major role in evaluation, with specific contributions from the psychiatric social worker in the project, we can foresee, in the demonstration model, an economy in personnel. Standardized physical health evaluation and standardized psychometric testing could be carried out by a nurse practitioner who has a combination of skills and experiences. Our finding was that a paraprofessional, such as a practical nurse, could design and carry out health intervention but for greater efficiency she/he should have formal knowledge of modern methods of health education as well as administrative skills. Such a combination of skills would be available in a professional health counselor who has had formal training in a school offering a master's degree program in health education.

6) Evaluation

	Unit	
a) Outcome criteria	Demon.	Classical
i) Health evaluation of clients		
Number evaluated by NP or MD assigned vs. non-MD	X	
ii) Case conference re: client disposition		
N referred for regular WIN registration	X	X
N referred for special programs (health services)	X	
N referred for special placement	X	
N referred for VR	X	
N referred for SSI	X	
iii) Changes in client status		
Health status following intervention (record review)	X	
AWGR	X	X
Job retention rate	X	X
Unassigned recipient pool	X	X
Special placement to regular WIN placement	X	X
iv) Cost-benefit analysis		

b) Analysis of outcome

Location A	Location B
Demonstration Unit	Classical Unit
Classical Unit	Demonstration Unit
Demonstration Unit	

Comparison of outcome criteria will be:

1. between localities
2. between units within a locality (demonstration vs. classical)
3. between demonstration units (demo 1 vs. demo 2 vs. demo 3)
4. between classical units (classical 1 vs. classical 2)
5. between all units

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APPENDIX A

Final Report: Feasibility Study

PHYSICAL REHABILITATION AND EMPLOYMENT OF AFDC RECIPIENTS

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October 1, 1975

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Principal Investigator: Daphne A. Roe, M.D.

16. Abstracts

A study was carried out to examine the feasibility of using health intervention as a means of increasing entry of welfare clients into job training. Objective screening procedures were used to define physical and mental health problems and handicaps in a New York State sample population. Common health disabilities identified in the experimental group included emotional handicaps such as sick role behavior, aversive handicaps including obesity, dental decay and locomotor handicaps with limited mobility. Health intervention included treatment of sick role behavior and other emotional problems by group counseling, weight reduction, exercise classes and treatment of specific medical and dental problems. Improvement in health status and solution of problems was correlated with compliance in relation to treatment. Clients with initial medical handicaps, successful in the health rehabilitation program, entered CETA job training and gained employment, as well as controls without chronic health problems over the same period.

17. Key Words and Document Analysis. 17a. Descriptors

Health intervention
Welfare clients
Job training
Health problems
Handicaps
Sick-role
Obesity
Dental decay
Limited mobility
Group counseling
Weight reduction
Treatment compliance
CETA

17b. Identifiers/Open-Ended Terms

Cornell Health Rehabilitation Program
ADC
Welfare status
Comprehensive health evaluation
Intrinsic handicaps
Predictors of physical performance
Hypochondriasis scores
Health intervention
CETA
Job training
Health and employment

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Outcome and recommendations 17

SUMMARY OF SALIENT FINDINGS

1. Finding: A significant number of persons having non-health eligibility characteristics for local job training and placement programs (CETA) claim medical problems as a reason for non-participation.

Implication: Registrants for job training should have health evaluation to determine actual health status and particularly the feasibility of remediable treatment to foster employability.

2. Finding: Among the health problems cited as reasons for non-participation in job training, those for which it is difficult to exclude some degree of disability figure largely. These include back problems, recurrent blackouts, migraine and nervousness.

Implication: Health evaluation must include testing procedures which can distinguish these conditions which confer a real handicap from those associated with hypochondriasis or malingering.

3. Finding: Sick role behavior is frequently found among welfare clients and is associated with long-term underemployment or unemployment, extrinsic handicaps including long-standing poverty situations, and family disharmony. Persons playing a sick role tend to have passive-dependent personalities. Sick role behavior is associated strongly with unemployment.

Implication: It is most important to use evaluation procedures which accurately delineate sick role behavior. Group therapy aimed at combatting sick role behavior must be provided to allow persons exhibiting such behavior to become employable.

4. Finding: Perceived health related job restriction by the client has been related to the number of current complaints, the hypochondriasis score, and negatively to performance in exercise tests. Measures of physical fitness as well as of intrinsic health handicaps have been found to have a predicted value in deciding whether clients are likely to respond to rehabilitation.

Implication: Objective definition of health status including motivation must continue to be a prominent feature of health intervention programs related to job training under the Manpower Administration. Reproducible measures of physical and mental health status of clients should be used to generate prognostic information for WIN/CETA agency personnel.

5. Finding: Aversive handicaps are similar in frequency to emotional problems in contributing to the health disorders of welfare clients. The commonest aversive handicap is obesity. Long-term obesity is particularly resistant to intervention in this population.

Implication: Programs for the treatment of obesity have to be designed by a nutritionist and physicians familiar with weight reduction programs for low income - low education groups.

6. Finding: Adequate health evaluation may require consultant opinion from medical and/or dental specialists for which ADC clients can be covered by Medicaid.

Implication: In establishing a health rehabilitation unit for ADC clients it is necessary to negotiate with the local Department of Social Services to insure that they will understand the necessity of referrals to area health services for evaluation as well as treatment purposes.

7. Finding: Non-compliance for prescribed therapies is characteristic of some clients, this detracting from the success of health intervention.
Implication: Contractual arrangements must be made with clients so that they have a time schedule in which to accomplish therapeutic goals. Token rewards should be offered for session attendance and expected achievement.

8. Finding: Clients geared to patch-up medicine and dental treatment are unfamiliar with the advantages of health rehabilitation, nor do they know how to seek or obtain optimal community health care.
Implication: Health education must have high priority with particular reference to upgrading health practices.

9. Finding: Non-attendance and/or lack of progress in therapeutic sessions after 3 months has been associated with overall failure to reach job readiness.
Implication: All clients should be re-evaluated after every 3 months. Those who fail to comply with advised treatment despite all encouragement and social assistance should be dropped from job related health intervention programs, except under extenuating circumstances.

10. Finding: Clients receiving active health intervention had more medical problems initially, were more likely to have emotional and aversive (unsightly) handicaps, and were less likely to be employed. In spite of these disadvantages, with rehabilitation, the success of the group on entering job training and/or employment was similar to that of a control group without such problems.
Implication: Based on this initial experience, it is projected that a job oriented health intervention program can increase employability.

11. Finding: As far as this feasibility study can show, successful health intervention does contribute to the employability potential of welfare clients.
Implication: It is highly recommended that the role of health rehabilitation as a means of returning unemployed persons to the work force should be further investigated.

12. Finding: It has been shown that health intervention for welfare clients can be established at moderate costs in a small town community.
Implication: It is recommended that similar units be established in other communities, more particularly in a large urban community, in order to evaluate whether the establishment of such health programs is an appropriate function of WIN.

CONCLUSIONS

Chronic medical problems have been identified among a group of welfare recipients which were related to job restrictions and unemployment. The most common health handicaps found in this group were emotional and aversive; the latter category including obesity and gross dental decay. Sick role behavior was common, as shown by hypochondriasis scores, and the total number of complaints. Physical performance was negatively related to obesity, hypochondriasis score, the number of current complaints, job restriction, age, and in general to the presence of emotional or aversive handicaps. Decision to employ health intervention was based upon the finding of remediable disabilities. Distinguishing characteristics of the active intervention group included that they had more medical problems initially, they were less likely to be working initially, they had overall higher handicap scores, they were more likely to have emotional or aversive handicaps, they performed less well on physical performance tests, they had fewer years of education, and they had incurred more Medicaid costs than the non-intervention group during the pre-study period. Health intervention included group and individual mental health counseling, weight reduction, exercise classes, and medical or dental referral for treatment.

Change in work status during the 8 months of the study was related in the intervention group to number of medical problems solved. In spite of their initial handicaps the overall changes in work and training status in the active intervention group were no worse than those of the controls who had less medical problems during the same period. It has been shown that, given the opportunity for comprehensive health intervention, as provided by the Cornell Health Rehabilitation Program, the chances of handicapped welfare recipients entering the job training programs and obtaining jobs may be increased to the level of those not having such health handicaps. Given the findings of this feasibility study, it is recommended that a demonstration project be established to show whether, in similar groups of ADC recipients with health handicaps, those receiving active health intervention have a greater chance of entry and success in WIN/CETA job training and ongoing employment. By including a larger population with differing demographic characteristics, it should be possible to determine whether it is an appropriate function of WIN/CETA to provide job related medical programs.

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I am first of all indebted to the professional staff of the Project. Without the efforts of Mrs. Nancy Brown, the Project coordinator, this program would not have been possible. She established liaison with area agencies, secured client referral, initiated the job motivation course, and worked with clients at all stages of their progress to further their entry into CETA job training and employment. Mrs. Muriel Dickey, nurse-educator, cooperated with me to set up the medical unit, carried out the health evaluation procedures, administered questionnaires, obtained objective health evaluation of clients, supervised in-house health intervention programs and

worked with clients to obtain their compliance with prescribed treatment. She also worked with Mrs. Brown on home visits, transportation, child care and client referral to area health professionals. More recently Mrs. Sally Nation has replaced Mrs. Dickey and has taken on the follow-up of clients. Dr. Curtis Hanners, the Project psychologist, has been a most active member of the team, developing innovative psychological testing techniques and being responsible for individual and group counseling of clients. He trained area paraprofessionals (nutrition aides) to work with him in counseling sessions, and to encourage clients' attendance at these sessions. Further, he has made the evaluation of psychological tests, thus contributing very significantly to the value of this report. Mrs. Julie Bleier, a graduate student in the Division of Nutritional Sciences and a trained dietitian, established and supervised the weight reduction and worked with clients to obtain their cooperation. Dr. Kathleen Eickwort worked closely with me in the design of the Project and, more especially, in all phases of data analysis. She supervised data coding, the writing of computer programs, designed scores of variables, carried out computer analysis, and provided me with the factual substance of this report.

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FIELD SURVEY

Background Information

In a number of studies, poor health status has been associated with unemployment or underemployment. Health problems are a particular deterrent to employability among those with few job skills. During the years 1971-1973 the present Principal Investigator carried out a health survey in Upstate New York. The sample population consisted in 469 middle-aged rural-urban fringe women who were, or had recently been, recipients of ADC. In this group, current medical complaints, nervous symptoms, and physical and mental disabilities were associated with unemployment. Most medical findings were preventable chronic ailments. Dental decay and untreated dental disease was prevalent. There was a high incidence of obesity which was associated with unemployment, an association explained by secondary disabling diseases including hypertension, diabetes, and non-rheumatic cardiac disorders. Disabilities arising in early life influenced current work status. Past employment was related directly to education and job skills, and inversely to the number of pregnancies.

On the basis of these findings, it was recommended that a necessity existed for the development of positive health attitudes in low income populations, as well as the provision of early and preventive medical and dental care, health education, the development of exercise and diet programs, to control obesity, and comprehensive rehabilitation by a team approach. It was suggested that these medical services be provided as a component of federal job training programs (Roe, D. A. and Eickwort, K. R. Health and nutritional status of working and non-working mothers in poverty groups. Research & Development Contract No. 51-36-71-02, Manpower Administration, USDL, 1973).

Sample Population

The caseload has consisted in 12 male and 59 female clients between the ages of 18 and 52 years, eligible except for health problems, for CETA job training programs. These persons were all residents of Tompkins County, New York. Client referral was from area agencies including the Tompkins County Department of Social Services, Cooperative Extension of Tompkins County, New York State Employment Service, the Tompkins County Personnel Office, EOC, OVR, Mental Health Rehabilitation, as well as via area health personnel including public health nurses and private physicians. Clients also came to the program through hearing of its existence via news media (see Table 1, Progress Report, June 1975). In all, 71 persons have been seen, of whom 1 did not complete a health evaluation, and 10 have not been in the program long enough for adequate follow-up. Demographic characteristics of the subsample of 60 persons for whom we have follow-up are shown in Tables 1-5 inclusive.

Description of the Project

The feasibility study was carried out between December 8, 1974 and August 15, 1975. During this period, the clients were interviewed, examined, and given health rehabilitation in the facility at the 4-H Cooperative Extension Building on Fulton Street in Ithaca, New York. Within the facility a room was equipped for physical examinations, and space was adequate for interviews and for group therapy sessions. Initial interviews were held with each client and at that time, health histories and work histories were obtained (Appendix 1). Indices of hypochondriasis were obtained using the questionnaire and scoring system from the MMPI Handbook (Dahlstrom, G. W. and Welch, G. S. An MMPI Handbook. The University of Minnesota Press, Minneapolis, 1960, p. 560). Motivation was assessed by the internal-external scale of Rotter, which determines predominance of internal motivation vs. passive dependency (Rotter, J. B. et al. Internal versus external control of reinforcement and decision time. J. Personality & Social Psychol. 2: 598-604, 1965) (Appendix 2). Intelligence tests were carried out including the Wechsler test and the Shipley-Hartford test (Wechsler, D. The Adult Intelligence Scale. New York: Psychological Testing Corp., 1944; Bartz, W. R. and Loy, D. L. The Shipley Hartford as a brief IQ screening device. J. Clin. Psychol. 26: 74-75, 1970). Current health complaints were obtained using a structured list. Physical examinations performed by the Project Director assisted by Mrs. Muriel Dickey, nurse-educator included a systems review, anthropometric measurements and an assessment of exercise performance using a Harvard Step Test, and hand grip as measured with a calibrated dynamometer (Appendix 3). Routine ancillary investigations of health status included laboratory studies (blood counts, biochemical profiles, tuberculin tests, sickle cell tests, serological tests for syphilis, and special tests relating to nutritional status), also routine chest x-rays and electrocardiograms where indicated by the health history or physical examination. Clients were referred to area physicians or clinics outside the Project for special systems evaluation. Dental examinations were carried out by consultant dentists, unless the client was able to furnish evidence of recent evaluation and/or treatment.

At the completion of health evaluation a staff meeting was held to decide on the need of individual clients for health intervention. A requirement for health intervention was based on the presenting symptoms, the findings on physical examination, psychological investigation, the ancillary testing procedures, and the results of diagnostic services. Participation in physical or mental health rehabilitation was voluntary. In-house health intervention included a weight reduction program, supervised by the nutritionist, Mrs. Julie Bleier, and exercise and health education program under the direction of Mrs. Muriel Dickey, and group or individual counseling supervised by Dr. Curtis Hanners, the Project psychologist. In each of these programs the number of projected treatment sessions was pre-defined. On an individual basis, medical treatment, surgical procedures, physical therapy, prescription spectacles, hearing aids or prostheses were provided through area physicians and dental treatment was carried out as required. Clients receiving health intervention were those who had remediable disabilities. Those having severe chronic mental or physical health problems which were not believed to be amenable to rehabilitation under the program were referred to area health agencies and/or to the local Office of Vocational Rehabilitation, or to the County Mental Health Department. Clients having no demonstrable health problems were directed into CETA job training or employment as openings became available.

Clients participating in the Project were assisted by the Project Coordinator in obtaining aid from local social as well as health programs in order to facilitate job training and employment, thus clients were taken to the Planned Parenthood Clinic of Tompkins County, legal aid was provided where needed, as well as child care and transportation. The services of county nutrition aides were obtained and these women worked closely with participants, making house-calls, giving dietary information, encouraging ongoing attendance for rehabilitation procedures, and assisting Dr. Hanners in the group counseling sessions. All medical services, other than those provided in-house, were covered by Medicaid except in those few instances where clients were not yet receiving such assistance. In these latter circumstances, medical services were covered by the Project.

All participants within the Project were invited to take part in three weekly job motivation classes. These sessions were conducted by Mrs. Nancy Brown and Dr. Curtis Hanners. They were designed to prepare clients for the work world and more specifically, to give them information on the requirements for job training, how to handle a job interview, as well as work attitudes and applications and employer-employee relationships. Particular attention was given in these sessions to the problem of how clients should handle health problems in the job interview and work situation. Short presentations were made by area employers, job counselors, by members of the Cornell Health Project team, including the Director, and by CETA job holders. Movies were shown and participants engaged in role-playing dialogues (Appendix 4).

Participants were interviewed and re-examined three months after the initiation of health intervention and then again after another three months, or at the completion of the feasibility project. At the time of these follow-up sessions, progress was evaluated as well as job readiness; the latter being assessed independently by the clients and by the Project staff (Appendix 5). Participants whose health problems were solved at the time of the first follow-up, or before that time, or between the time of the three months and the latter follow-up, were referred for CETA job training or job placement.

Detailed findings described below relate to the 60 clients for whom we had a period of not less than three months follow-up.

Employment History

In general, it was found that clients had poor work histories, having been employed for a short period of time in low paying jobs. The fact that four clients had never worked, and that 50 clients had worked for not more than five years totally, can only be explained in part by the number of young adults in this sample. Clients had most frequently held unskilled jobs as operatives or service workers, or they had been in semiskilled jobs, particularly in clerical work (Tables 6-10).

Medical History

The medical history of each client from birth was obtained. Each illness or accident was tabulated by diagnosis according to the International Classification (Eighth Revised International Classification of Diseases (ICDA), PHS Publ. No. 1693, USDHEW/PHS, Washington, D. C., Vol. 1, 1967, Vol. 2, 1968).

Most of the medical problems cited in the history had arisen in adult life, and in this period mental health problems had frequently occurred including predominantly neuroses, variously described as nervous breakdowns, anxiety, depression, and nervousness. Most physical problems mentioned as occurring in adult life were of long-standing, including back problems, as well as late effects of injury and surgical procedures (Tables 11-14). The medical history score for each period of the person's life was calculated as follows: 4 points for each problem causing permanent major disability; 2 points for each problem not causing major disability, but recurrent, continuous or lasting more than 6 months; and 1 point for each other problem mentioned. The overall medical history score equals the sum of the scores at birth, preschool, during the school years, post-school, and during the past year.

Current health complaints were frequently multiple. The most common symptoms were frequent nervousness, frequent tiredness, breathlessness on exertion, frequent urination, frequent headaches and tender gums; also frequent backaches (Table 15).

Physical Examination

Physical examination showed a rather low frequency of severe abnormalities. Among the commoner abnormalities encountered were dermatoses, limitation in movements of one or more parts of the body, deformities, usually minor, and other musculoskeletal problems (Table 16). Dental decay (dental caries and/or periodontal disease) and obesity were prevalent and frequently so severe as to constitute an unsightly appearance which would provide a handicap to employment (Tables 17, 18). Measures of obesity included weight and triceps skinfold thickness. Triceps skinfold thickness was negatively correlated with performance on the Harvard Step Test ($r = -.43$, $p < .001$). On the other hand, the taller the client, the better they performed on the Harvard Step Test ($r = .45$, $p < .001$).

Mental Health Assessment

As anticipated from the medical history and the number of nervous complaints, psychological problems were frequently identified among the clients. There were two with mild to moderate, and 13 with severe, neuroses. Ten persons showed evidence of emotional immaturity, and in two cases this was severe. Two clients had severe behavior disorders, and one was psychotic. Three clients had mild to moderate degrees of mental retardation. Five persons had an impaired learning ability, which includes those with mental retardation. Some degree of intellectual handicap was found in eight clients, and of these, three had severe intellectual handicaps (Tables 19-26). The hypochondriasis score was very highly correlated with the number of current symptoms ($r = .83$, $p < .001$), and with the health related job restrictions cited by the client ($r = .42$, $p < .001$), and with the degree of emotional handicap ($r = .38$, $p < .001$).

Intake of Medication

Fifty percent of the sample were taking medications. The commonest groups of prescribed drugs being taken were analgesics and tranquilizers. It was also found that 38.3% of the sample were taking over-the-counter drugs to relieve frequent headaches. This rather high usage of pain killers and psychoactive drugs may be associated with the prevalence of emotional problems (Tables 27-29).

Assessment of Handicap

Handicaps encountered among clients were classified according to the system developed by Agerholm (Agerholm, M. Handicaps and the handicapped. A nomenclature and classification of intrinsic handicaps. Roy. Soc. Health J. 1: 3-8, 1975). This system offers a method for the identification and grouping of medical handicaps which is valid for the individual regardless of his/her age; of the circumstances in which he/she lives, and of the context in which he/she is reviewed. Handicap or intrinsic handicap is identified in this system as a long-term disadvantage which adversely affects an individual's capacity to achieve the personal and economic independence which is normal for his/her peers. Key handicaps within this system include locomotor, visual, communication, visceral, intellectual, emotional, invisible, and aversive handicaps. Any one person can have one or several handicaps, or components of handicaps. A handicap score was developed by counting one for each mild to moderate component of each intrinsic handicap, and two for each severe component under the Agerholm system. By this method it was found that 31 clients (51.7% of the sample) had aversive handicaps which included gross obesity, dental decay, deformity or unacceptable smell. Twenty-eight persons (46.7% of the sample) had emotional handicaps, and 15 of these had neuroses. Intellectual handicaps were found in 8 persons (13.3%), invisible handicaps including pain disorders occurred in 6 persons (10%), locomotor handicaps in 12 persons (20%), communication handicaps in 5 persons (8.3%), visceral handicaps including disorders of ingestion or excretion in 3 persons (5%), and visual handicaps including severe visual restriction in 1 person (Table 30).

Height as an Indicator of Physical and Work Performance

In our sample population the taller clients were healthier and had a better history of work performance. Height was directly related to ability to perform in the Harvard Step Test and to the level of performance with the hand-grip dynamometer (HEIGHT vs. STOPWHEN $r = .45$, $p < .001$, HEIGHT vs. HANDGRIP $r = .53$, $p < .001$). The taller members of the sample also had less initial medical problems, lower hypochondriasis scores (a measure of sick role), less emotional handicaps and less perceived job restrictions (NUMINPR $r = -.47$, $p < .001$, HYPSCORE $r = -.33$, $p = .005$, EMOTIONL (Handicap) $r = -.34$, $p = .004$, $r = -.25$, $p = .026$). Those who were relatively taller also had less health complaints ($r = -.22$, $p = 0.45$), were thinner (SKINFOLD $r = -.23$, $p = .043$), and had less overall handicaps as determined by the Handicap score (HANDSCORE $r = -.30$, $p = .01$). It is also significant that height was related directly to education ($r = .27$, $p = 0.19$), and negatively to age ($r = -.27$, $p = .018$).

Inverse relationships between height and early neglect associated with malnutrition have previously been identified. In our previous study conducted between 1971 and 1973, including a sample population of very low income women, it was found that height was related to education ($r = .12$, $p \leq .01$); to the total number of years employed as a percentage of potential years of employment ($r = .11$, $p \leq .01$). It was also negatively related to the number of medical problems at birth ($r = -.08$, $p < .05$) and to the number of health problems in the medical history ($r = -.08$, $p < .05$). Further height was directly related to total income ($r = .11$, $p = .007$). From these findings it was concluded that the shorter the woman was, the more likely she was to have been unemployed, low in income, poorly educated, and to have had medical problems at birth and during later life (Roe, D. A. and Eickwort, K. R., cited previously). It has been shown by other studies that, whereas height is determined by genetic factors, early malnutrition and disease including infection and interactions between these variables can result in stunted growth (Bakwin, H. and McLaughlin, S. M. Secular increase in height: is the end in sight? Lancet 2: 1195, 1964; and Chavez, H. Ecological factors in the nutrition and development of children in poor rural areas. Proc. Western Hemisphere Nutrition Congress III, 1971, Futura Publ. Co., 1972, p. 265).

Findings from the present study serve to emphasize the fact that those who come from a low socioeconomic group may not only have suffered physical disadvantages in early life including primary and secondary malnutrition, which had an adverse effect on growth, but more importantly that these persons may have later disadvantages in motivation for, or performance in, work or physical work performance. From the available information it is, of course, not possible to say that association of shortness, poor education and numerous health problems through life are individual factors predictive of social failure, but rather that such factors taken together may indicate a bad prognosis with relation to employability. In support of the latter statement, it was found in the present study that height was related directly to the maximum pay categories in previous employment (r = .23, p = .038), and that progress under health intervention conducted by the Project was also directly related to height, i.e. the number of medical problems remaining at follow-up was inversely related to height (progress score r = -.32, p = .013).

Handicaps of the Obese

Evidence was obtained from the present study that obesity confers physical, emotional, and social disadvantages. The overall handicap score was directly related to fatness (r = .34, p = .005). Physical performance as reflected by the Harvard Step Test was negatively related to obesity (r = -.43, p < .001). Although it was found that the fatter the client, the greater the number of visits they made to the Project (r = .39, p < .001), remaining problems after health intervention were greater in the fatter clients (r = -.28, p = .032). Change in welfare status during the period of study was inversely related to fatness (r = -.30, p = .012).

Relationships Between Job Restrictions and Health Handicaps

Job restrictions cited by the clients were very significantly related to age (r = .48, p < .001), to the handicap score (r = .47, p < .001), to the number of medical problems occurring in adult life (r = .49, p < .001), and to the number of initial health problems defined (r = .42, p < .001). There was also a very significant relationship between job restriction and staff time spent with each client (r = .39, p < .001). A significant inverse relationship was found between the perceived job restrictions and education (r = -.30, p = .01); also an inverse relationship to previous earnings (PAYCAT r = -.31, p = .01). Previous Medicaid costs were very significantly related to job restriction (r = .45, p < .001).

Relationship Between Previous Earnings and Health Parameters

Levels of pay in previous jobs were inversely related to the number of previous medical problems (MEDHISSC r = -.20, p = .07), to the presence and severity of aversive handicap (r = -.25, p = .035), to the number of initial medical problems (NUMINPR r = -.24, p = .054). Total Medicaid charges before entry into the Project (DAYACOST $r = -.30$, $p = .016$) and to costs for Medicaid after entry into the Project (DAYBCOST $r = -.29$, $p = .017$). Education showed a direct relationship to previous pay categories ($r = .28$, $p = .02$), and those with higher previous pay categories were more likely to be working at follow-up ($r = .30$, $p = .013$).

These correlations show complex relationships between health and social factors in defining previous work and work potential.

Characteristics of Clients in the Health Intervention Program

Health intervention was made available to clients on the basis of the presence of remediable health problems and acceptance by the client of recommended treatment modalities.

Differences between the "active intervention group" and the others ("controls") were examined by rank correlations (Spearman's r). Differences which resulted in their being chosen for active intervention were as follows:

1. This group had more medical problems initially ($r = .73$, $p < .001$).
2. They were less likely to be working initially ($r = -.46$, $p < .001$).
3. They had higher overall handicap scores ($r = .63$, $p < .001$).
4. They were more likely to have an "intrinsic emotional hamdicap" ($r = .41$, $p < .001$) or an intrinsic aversive handicap ($r = .54$, $p < 1001$).
5. They had a higher "medical history score" since leaving school till the past year ($r = .48$, $p < .001$), a larger total number of problems mentioned on the medical history ($r = -.36$, $p = .002$), and a higher overall medical history score ($r = .46$, $p < .001$).

Other incidental distinguishing characteristics of the active intervention group were:

1. They were shorter ($r = .35$, $p = .003$).
2. They were fatter (thicker triceps skinfold, $r = .44$, $p < .001$).
3. They stopped after a shorter time on the Harvard Step Test ($r = .51$, $p < .001$).
4. They had higher hypochondriasis scores ($r = .44$, $p < .001$).
5. They had more children ($r = .39$, $p < .001$).
6. They had completed fewer years of formal education ($r = -.36$, $p = .002$).
7. They had incurred more costs per day on Medicaid than the others during the control period (re. Jan. 1, 1974 - Dec. 1, 1974, $r = .38$, $p = .004$).

Results of Health Intervention

Differences between the health intervention groups and the controls during the duration of the study were examined. It was found that the health intervention group

1. Had more phone calls and personal calls as well as other contacts with the Project staff (phone calls $r = .57$, $p < .001$); personal calls

r = .57, p <.001). They also initiated more self contact (r = .52, p < .001); received more staff-initiated contacts (r = .50, p <.001); and took up more hours of staff time (r = .61, p < .001).

2. They incurred more costs per day on Medicaid than others during the Project period (r = .37, p = .002); and more costs per day on Medicaid that were traced to Project referrals or costs (r = .40, p < .001).

3. They showed a greater decrease in hypochondriasis scores than the non-intervention group (r = .43, p < .001).

At three months, the active intervention group still had a greater percentage of their medical problems not yet solved (r = -.58, p < .001). Many of those in the non-intervention group had one or no medical problems initially.

In spite of their initial handicaps, as documented above, by August, the overall changes in work and training status in the active intervention group were similar to that of the control during the same time (defining variable WORKAUCH as: -1 -left job or training, now not employed and not in training; 0 -no change; +1 -got job or entered training, we find that the rank correlation of WORKAUCH with INTRVENE is .01, p = .5, n.s.).

It is necessary to delineate the health problems that were easiest to solve, and the clients who benefitted most from health intervention. In general, it was found that clients with easily definable single health problems, without overlay of sick role behavior, were easiest to treat. Clients in this category were closer to work readiness on entry into the Project and also had the advantages of better health and work histories. Conversely, those with multiple health problems on entry into the Project, including overt sick role behavior, responded less well to treatment. Another question which we have had to ask is whether solution or partial solution of health problems contributed to or promoted entry into job training and employment.

Results of Health Intervention

We have obtained both direct and indirect evidence that health intervention contributed to employment at the time of follow-up. Clients working at the three months follow-up period were more likely to have received health intervention and less likely to have residual health problems.

Problems and Progress

We must address ourselves to consideration of the specific problems encountered which were a hindrance to the performance of the feasibility study. At the beginning, client referral was slow, and those clients who were sent to see us were those who had made little or no progress with other agencies. They were multi-problems people with numerous health problems, a poor work history including very limited job skills, and they had been in receipt of welfare over a long period of time. Thus, we started out with hard to reach, hard to teach clients whose motivation to overcome health problems was not well developed. We found ourselves adopting a custodial care role with those clients least likely to succeed. This meant that these persons were most likely to take up staff time with phone calls, visits and other supportive activity. Another problem which we encountered was the limited number of job training programs in the area, which clients could enter through the aegis of CETA. Indeed, initially job training other than OJT was limited to courses at the Tompkins-Cortland Community College where clerical skills were offered. Limitation in job openings was also apparent. Initially some of our clients did poorly in job interview, either because they presented themselves badly, or because they referred back to previous health problems which had previously been work deterrents.

Non-compliance with prescribed treatment was not uncommon. Less motivated clients missed appointments whether these were for health groups working within the Project or outside medical visits on referral.

Greatest progress and health change was achieved in relation to dental problems, visual impairment (provision of corrective glasses), hearing difficulties (provision of hearing aids), musculoskeletal problems (physical therapy), and overcoming sick role behavior (individual or group counseling). Progress in weight reduction was modest, and this may be attributed in part to the fact that the program was only offered for 12 weeks as active intervention, and because our clients had very long-term obesity. Treatment progress at the end of the three months follow-up period is shown in the following tables (Tables 31-35).

In examining the number of medical problems solved or partially solved at the end of three months (Table 36), as well as the number of old problems unchanged at three months, it can be seen that clients' progress has been slow (Table 37). Residual medical problems consisted chiefly of emotional disabilities and obesity. Slow response of these health problems to therapy was not unexpected, more especially because of their chronicity.

Despite slow improvement in the health of some clients, entry of clients into job training and/or employment increased with time of Project participation. Whereas initially 39 of the 60 clients were not working and 21 were working, and at 3 months the same number were working or in job training, as of August 15, 1975 24 clients were working, 32 not working, and for 4, status was unknown. It is more meaningful to state that as of August 15th, 8 persons were in training or working who initially had been outside the work force. However, as of the latter date, 3 persons who were initially working or in training were now unemployed, and 45 of the clients had stayed in their original employment or non-employment status. It is to be noted that 11 of the clients who were working at the time of entry into the Project had health problems, and would not have been able to maintain their training or work status but for the availability of the program (See also Table 38 showing employment status as of Sept. 1).

Participation of Clients in CETA Job Training or Employment

Participation of Cornell Health Rehabilitation Project clients in Tompkins County CETA programs was such that between January, 1975 and

September, 1975, 23 clients held CETA jobs (Titles I and VI), 4 clients were enrolled in the Spring 1975 secretarial course at the Tompkins-Cortland Community College, 3 took part in a summer remedial reading program, and 4 are participating in the Fall 1975 secretarial course at the Community College. The total Tompkins County CETA program population were as follows:

Title I, Spring 1975 secretarial course -15
Summer remedial reading - 4
Fall 1975 secretarial course - 17
Title VI, approved for training - 23.

Indicators of the Effectiveness of Health Intervention in Terms of Employability

Changes in health status brought about by intervention range from solution of physical problems to conquest of sick role behavior. The professional team had a strong impression that as health problems were overcome, so the clients felt they could play a role in determining the direction of their lives or life style. In support of these impressions, verbally communicated by the staff, it was found that change in the internal-external score indicating increased self-confidence was directly associated with the reduction in the number of complaints between the initial visit and the three months visit ($r = .26$, $p = .045$). Further, those who showed a change in the internal-external score in the direction of self-reliance were more likely to be working in August ($r = .39$, $p = .005$).

Medicaid Expenditures and Client-Related Medical Charges to the Project

Medicaid charges were obtained for each client for a control period before the entry into the program, and for the duration of the Project. Medicaid charges as computed from records obtained from the Tompkins County Department of Social Services were divided as follows:

1. Costs during the control period before the Project started, viz. January 1, 1974 - December 1, 1974.
2. Medicaid charges after initial contact of the client with the Project until the termination of the feasibility study or the last billed item on Medicaid records.
3. The costs during the latter period for which the Project was responsible because of referrals.
4. Costs for which the project was responsible but were not yet billed.

These charges in the four different categories are itemized in Table 39. In examining the costs in Category 1, it can be seen that the items requiring the greatest expenditure per client were doctors' office visits, pharmacy charges, hospitalization, and appliances. During period 2 after the clients had begun to attend the Project, the Medicaid paid costs appeared to be reduced for doctors' office visits and accident room visits. In view of the dissimilar periods for which Medicaid costs were obtained before and after the Project, these differences must be interpreted cautiously. Medicaid costs for which the Project was responsible through referrals were chiefly in the categories of hospitalization, dental visits and charges for appliances.

Medicaid charges for clients during the period before the Project started were very significantly related to the charges for these clients after the Project started (DAYACOST vs. DAYBCOST $r = .55$, $p < .001$). DAYACOST was also very significantly related to the medical history score during the school period ($r = .39$, $p < .001$), to the medical history score during adult life ($r = .58$, $p < .001$), and to the number of medical problems cited in the last year ($r = .45$, $p < .001$). The higher the Medicaid expenditures for clients prior to entry into the Project, the greater number of contacts and visits they made to the unit (NUMCALLS $r = .47$, $p < .001$; NUMVIST $r = .49$, $p < .001$; STAFINIT $r = .56$, $p < .001$; NUMSUPP $r = .38$, $p < .001$). Those working at the three-month follow-up visit were less likely to have sustained high Medicaid expenditures prior to entry into the Project (WORKIN2 $r = -.07$, $p < .001$).

Medicaid costs totally during the period of the Project for clients were directly related to health referrals made by the Project team ($r = .54$, $p < .001$). Medicaid costs during the study were also very significantly correlated with the total number of medical problems ($r = .43$, $p < .001$), to a number of medical problems occurring in adult life ($r = .49$, $p < .001$), and to the total medical history score ($r = .46$, $p < .001$). Clients working at the three months follow-up incurred lower Medicaid expenditures during this period ($r = -.39$, $p < .001$).

Medicaid costs attributable to our referrals were related very significantly to the total number of initial medical problems ($r = .50$, $p < .001$). It is of particular importance to note the Medicaid costs attributable to Project referrals were higher also in those who had more medical problems remaining at the three months follow-up visit ($r = .39$, $p < .001$), and were inversely related to whether the client was working at the time of follow-up ($r = -.31$, $p < .009$). From this it is inferred that those with multiple initial health problems are not only more costly with respect to health intervention, but also that their chances of being rehabilitated so that they can enter the work force within a short period of time is less than that of other clients with less health handicaps. However, the percentage of medical problems solved was also related to the Medicaid referral costs attributable to the Project ($r = .24$, $p = .053$). Change in hypochondriasis scores was inversely related to Medicaid costs attributable to the Project, which suggests that a persistent sick role behavior may have accounted for some of the referrals.

Project Costs (December 1, 1974 - August 1, 1975)

The costs of undertaking the feasibility study were moderate and less than those anticipated. Savings relative to the Project budget were made in the personnel category, by reduction in the total number of staff. Two full-time staff worked with the Project; that is, the nurse-practitioner, Mrs. Muriel Dickey, and the Project coordinator who also acted as social worker, Mrs. Nancy Brown. The position of mental health counselor, as invisaged by the original budget, was replaced by the Project psychologist, Dr. Curtis Hanners, who worked half-time and was paid by combining the projected budgeted salaries for the mental health counselor and a physical therapist. No physical therapist was employed, since it was possible to refer clients under Medicaid to the Rehabilitation Unit of Tompkins County Hospital. A dental hygienist was not employed, because clients were referred to area dentists for evaluation as well as treatment. Part-time secretarial help was obtained through employment of several persons on an hourly basis. The statistician who worked with the Project on a 50% time basis received the salary payment originally intended for the statistician, as well as the coder-keypuncher. An office cleaner was not required, since these services were carried out by the personnel at the 4-H Cooperative Extension Building. Although it was found that this staff could manage the Project and carry out the necessary duties efficiently, a need for further clerical assistance and the expertise of a social worker was particularly identified as the Project proceeded.

Savings on the original budget were also made in the categories of consultants, supplies, travel and services, as well as communication. Lower costs in these categories were only maintained because of the temporary nature of the Project. For example, purchase of medical equipment was held at a minimum although it is now considered highly desirable that further equipment and supplies for health evaluation should be obtained in order to obtain an adequate objective estimate of health status of clients. Structure alterations in the Project facility which are urgently required to offer privacy to staff and clients as well as proper accommodations for group health intervention sessions were not carried out because the principal investigator was unsure of the continuity of the Project.

Nevertheless, it has been demonstrated that health evaluation and rehabilitation can be carried out in relation to a work training program using a small professional staff, aided as was the case in the feasibility study, by paraprofessionals (Table 40).

OUTCOME AND RECOMMENDATIONS

Owing to the short duration of this feasibility study, we were not able to assess the long-term effects of health intervention on clients' work potential. In our sample population, it was clearly demonstrated that health handicaps which limit or prevent entry of welfare recipients into job training or employment are complex, being conditioned by sick role behavior, lack of motivation, long neglect, emotional problems, and obesity. Unless welfare clients are desirous to enter the work force, they are not anxious to obtain optimal health. Indeed, the prominence of sick role behavior suggests that health complaints are used as a means of excusing social and economic failure. In order for these people to acquire physical and emotional fitness for work, they must first be helped to understand the nature of their disabilities. They must be encouraged to see work as a positive personal advancement. Client profiles and their intervention are given in Appendix 6. They must also have available a health team who can fully evaluate their problems, offer remedial health intervention, and act as advocates for them in the established health care delivery systems.

Routine health screening, as available in most communities, is frequently inadequate to the needs of welfare clients who are potential WIN/CETA registrants. In order to understand their health complaints and reactions to these problems it is necessary to know that symptoms may often be cited for which it is difficult to exclude some disability in relation to employment. Recognition of sick role behavior is not easy, nor is the recognition of the synergistic effects of social (extrinsic) and health (intrinsic) handicaps. In the feasibility study we have developed methods for obtaining information which can be used in developing a complete health evaluation. Measures of physical fitness as well as of intrinsic health handicaps have been found to have a predictive value in deciding whether clients are likely to respond to rehabilitation. Common intrinsic handicaps encountered include emotional problems and aversive handicaps, and in the latter category, the most common has been obesity.

Full health evaluation has required the collaborative efforts of the professional team of the Project, as well as area dental and medical professionals. Outside services have been covered by Medicaid, in the case of our welfare clients. Referral of clients to these local health professionals and actually taking them to meet medical or dental appointments has been an integral function of the Project.

Beneficial effect of health intervention with respect to employability has often not become immediately apparent. Clients geared to patch-up medicine and dental treatment are slow to learn the advantages of full-health rehabilitation.

Non-attendance and non-compliance have also been problems. However, we have established that whereas clients who entered our active health intervention program had more medical problems initially, and were more likely to have emotional and aversive handicaps, and were less likely to be employed at all on entry, the success of this group on entering job training and/or employment was similar to that of a control group without such problems. It was further shown that the expenses of health intervention for welfare clients can be established at moderate costs in a small town community.

Based on the findings of this feasibility study, it is recommended that a full scale demonstration project be established forthwith, with essential objective of developing a model health care delivery system designed precisely to the needs of WIN/CETA clients. In order to establish the practical value of such a program to a variety of communities, it is recommended that units be established in a semi-rural community (Ithaca) and also in an urban community (Syracuse). It is recommended that the demonstration project be concerned with 1) health evaluation; and 2) health intervention.

Methods must be developed for the precise and rapid assessment of health status and for success of health for intervention. A health intervention system must be developed such that client compliance is optimized and health care be directed towards employment needs.

Under the auspices of the demonstration project it should be possible to determine to what extent ADC recipients with health-related work disabilities can be returned to the labor market through physical and mental rehabilitation: the hypothesis being that these health disabilities need to be corrected before a job can be held successfully. It has to be proven whether or not expenditures to health rehabilitation, facilitating employability, will be a cost-benefit overlying ADC recipients with health problems to remain outside the work force or to take care of their own health difficulties. It must further be established whether health rehabilitation for remediable disorders is an appropriate function of the WIN/CETA programs and to what extent health rehabilitation is an overall function of projected Manpower programs. Implementation of these recommendations is the objective of the demonstration project which has recently been funded by the Manpower Administration of the United States Department of Labor.

APPENDIX B

COMPARISON OF FEASIBILITY AND DEMONSTRATION PROJECTS

During the period between 12/2/74 and 10/1/75, a feasibility study entitled "Physical Rehabilitation and Employment of AFDC Recipients," contract/grant number 51-36-75-01 was conducted in Ithaca, New York under the direction of the principle investigator. Aims of the study were to examine the feasibility of using health intervention as a means of increasing entry of welfare clients into job training. During the period of the study, the caseload consisted of 12 male and 59 female clients between the ages of 18 and 52 years, eligible except for health problems, for CETA job training programs and/or placement. These persons were all residents of Tompkins County, New York. Client referral was from area agencies including the Tompkins County Department of Social Services, Cooperative Extension in Tompkins County, New York State Employment Service, Tompkins County Personnel Office, EOC, OVR, Mental Health Rehabilitation, as well as via area health personnel including public health nurses and private physicians. Clients also came to the program through hearing of its existence via news media.Clients referred from the various agencies or self referred were interviewed and examined in the project facility at the Cooperative Extension Building on Fulton Street in Ithaca, New York. At that time, the project staff consisted in the director, the coordinator, the project nurse, who had formal training as a nurse educator, a psychologist and a nutritionist who was in graduate training at the time.

Of clients who came to the project, all presented with self-defined health problems and those who had physical examinations or who in psychological evaluations were found to have remediable disabilities were offered health intervention. Those having severe chronic mental or physical health problems which were not believed to be amenable to rehabilitation under the program were referred to area health agencies and/or to the local office of Vocational Rehabilitation and/or to the County Mental Health Department. Clients having no demonstrable health problems were directed into CETA job training or CETA or other employment as openings became available. There was no defined control group. All participants within the project were invited to take part in job motivation classes conducted by the project coordinator and the psychologist. These sessions were designed to prepare clients for the work world and more specifically to give them information on the requirements for job training, how to handle a job interview, as well as work attitudes and applications and employer-employee relationships. Particular attention was given in the sessions to the problem of how clients should handle health problems in the job interview and work situation. Participants were interviewed and re-examined three months after the initiation of health intervention and then again after another three months or at the completion of the feasibility project. At the time of these follow-up sessions, progress was evaluated as well as job readiness, the latter being assessed independently by the clients and by the project staff. Health intervention was through in-house programs including weight reduction classes, health education, and mental health counseling. Evidence was obtained at the time of follow-up that health intervention contributed to employment. Clients working at the three-months follow-up period were more likely to have received health intervention and less likely to have residual health problems.

As can be understood from this description of the feasibility study, it differed in several major respects from the demonstration project. Staffing was different in that the staff included a trained psychologist and a nurse educator. Multiple sources of client referral were used. However, the project facility was the same as the Ithaca facility used in the demonstration project. The system of intervention differed in that more emphasis was placed on job motivation. Findings with respect to common health problems and handicaps in the clients were similar in the feasibility study and the demonstration project. Several problem areas were identified during the course of the feasibility study. At the beginning, client referral was slow and those clients who were sent into the program were those who had made little or no progress with other agencies. These essentially were the kind of clients who were sent to us in the Syracuse program during the demonstration project. However, by this time these multiproblem people with numerous health difficulties and long welfare dependence were less likely to be referred to the Ithaca project since the referral agency (Department of Social Services) was aware that they were less likely to be successful in a remedial health program. The project staff learned that it was hard to teach clients whose motivation to overcome health problems was not well developed. The project staff found themselves adopting a custodial care role with those clients least likely to succeed. Another problem which was encountered was the limited number of job training programs in the area which clients could enter through the aegis of CETA. Again, looking back on these problems we are reminded that these were the same kinds of difficulties that have more recently been encountered in WIN clients in our Syracuse project, including the limited number of job slots offered through the WIN program.

In both the feasibility and the demonstration project non-compliance with prescribed treatment was not uncommon. Less motivated clients missed appointments in both projects whether these were for health intervention groups working within the project sites or for medical visits by referral. Enhanced ability to work with the Tompkins County Department of Social Services and the New York State Employment Service in Ithaca during the demonstration project relates to the fact that they came to know and value our services during the period of the feasibility study. Though administratively the Cornell Health Rehabilitation Project never became a component either of the Department of Social Services or of the Employment Service by general agreement, CHRP was accepted as the agency for health determination and rehabilitation of clients who presented with health problems at these agencies which were believed to interfere with their employment or job training.

APPENDIX C

TABLES

Table 51. Number of persons who lived with client, total sample

Number of persons	Number	Percent
Lives alone	31	12.1
1	52	20.3
2	57	22.2
3	50	19.5
4	31	12.1
5 or more	35	13.8
Total	256	100.0

Table 52. Ages of other household members, total sample

Ages of household members	Number	Percent of all household members
Infants < 1 yr.	8	1.2
1 - 5 yrs.	118	18.4
6 - 12 yrs.	221	34.4
13 - 17 yrs.	130	20.2
18 - 20 yrs.	42	6.5
21 - 25 yrs.	37	5.8
26 - 30 yrs.	32	5.0
31 - 35 yrs.	13	2.0
36 - 40 yrs.	14	2.2
41 - 45 yrs.	4	.6
46 - 50 yrs.	9	1.4
51 - 55 yrs.	6	.9
56 - 60 yrs.	3	.5
61 - 65 yrs.	3	.5
71 - 75 yrs.	2	.3
76 - 80 yrs.	1	.2
Total	643	100.0

Table 53. Marital status of other household members

Category	Number	Percent
Married to client	62	9.8
Married to other	17	2.7
Single	526	82.7
Divorced	13	2.0
Separated	10	1.6
Widowed	8	1.3
Total	636	100.0

Table 54. Relationship of household members to client, total sample

Category	Number	Percent of all household members
Relatives		
Child	476	70.9
Spouse	62	9.2
Father	4	0.6
Mother	5	0.8
Grandchild	17	2.5
Brother	11	1.6
Sister	4	0.6
Cousin	6	0.9
Aunt	1	0.2
Uncle/brother-in-law/ stepfather	5	0.8
Sub-total	591	88.1
Nonrelatives		
Male friend	41	6.1
Female friend	25	3.7
Son/daughter of friend	14	2.1
Sub-total	80	11.9
Total	671	100.0

Table 55. Source of emotional support

Category	Number	Percent of positive responses
Emotional support from spouse	28	8.8
Emotional support from parent	42	13.2
Emotional support from child	21	6.6
Emotional support from clergy	13	4.1
Emotional support from friend	103	32.4
Emotional support from God	33	10.4
Emotional support from a relative	31	9.7
Emotional support from an agency	29	9.1
Emotional support from doctor	10	3.1
Emotional support from pet	8	2.5
Emotional support from no one	26	11.9
Total	318	100.0

Table 56. Work/educational status of other household members, clients who had other household members

Category	Number	Percent
Works, supports	53	8.3
Works, no support	14	2.2
Not working or in school	83[a]	13.0
In school	384	60.1
In training	12	1.9
Preschool	93	14.6
Total	639	100.0

[a] Reasons why other household members weren't working or in school: 30 could not find employment, 7 were not trained to work, 7 were too old to work, 27 had physical or emotional problem, 7 had acute medical problem, 8 had chronic medical problem, 6 had emotional problem, 4 were alcoholics, 3 were mentally retarded, 4 had a prison record (some gave more than one reason).

Table 57. Public assistance and other non-wage income to other household members

Category	Number	Percent
A.D.C.	486	91.5
SSI	14	2.6
OVR	1	0.2
Home Relief	2	0.5
Disabled Veteran	2	0.5
Social Security	13	2.4
Unemployment insurance	1	0.2
Father or ex-husband supports	11	2.1
Government allotment (father military)	1	0.2
Total	531	100.0

Table 58. Period of time client had lived in same place, total sample

Category	# Clients	% Sample
Under 3 months	72	28.7
Under 6 months	37	14.7
Under 1 year	42	16.7
Under 5 years	70	27.9
5 years or more	30	12.0
Total	251	100.0

Table 59. Number of moves by recency of move, total sample

Category	Moves in last year		Moves in last two years	
	N	%	N	%
None	114	43.8	88	33.8
1	79	30.4	74	28.5
2	21	8.1	34	13.1
3	23	8.8	16	6.2
4	10	3.8	16	6.2
5 or more	13	5.0	31	7.7
Total	260	100.0	260	100.0

Table 60. Number and percent of clients who responded positively to items related to dwelling characteristics, total sample

Category	# Clients	% Sample
Expect to move within next year	84	33.5
Happy with living arrangements now	167	66.8
Meals included	9	5.4
Cooking privileges	156	96.9
Share kitchen	20	8.0
Share bathroom	20	8.0
Have a TV set	224	90.3

Table 61. Type of present dwelling unit, total sample

Category	Number	Percent
House	58	23.1
Trailer	19	7.6
Apartment	166	66.1
Other	8	3.2
Total	251	100.0

Table 62. Number of housing units in structure and number of rooms in housing unit, total sample

Number	Housing units in structure		Rooms in housing unit	
	N	%	N	%
One	69	27.5	17	6.8
Two	69	27.5	3	1.2
Three or four	38	15.1	60	24.2
Five or six	22	8.8	119	47.8
Seven or more	53	21.1	50	20.0
Total	251	100.0	249	100.0

Table 63. Ownership of housing unit, total sample

Category	Number	Percent
Landlord	214	84.9
Housing authority	28	11.1
Client	3	1.2
Client, (mortgaged)	7	2.8
Total	252	100.0

Table 64. Person or agency that pays rent, total sample

Category	Number	Percent
Client	12	4.9
Welfare	193	78.1
Others	10	4.0
Client and welfare	14	5.7
Client and others	6	1.6
Welfare and others	6	2.4
Other sources	8	3.2
Total	247	100.0

Table 65. Responses to health attitudes and awareness questionnaire, total sample

Category	Number[a]	Percent
1. Regular family doctor or clinic		
No	51	20.2
Yes	202	79.8
Total	253	100.0
2. Time of last physical exam		
Never	5	2.0
More than 5 years ago	7	2.8
Less than 5 years ago	56	22.2
In last year	184	73.0
Total	252	100.0
3. Who gave last physical exam		
Own MD routine exam	100	40.3
My MD health problem	62	25.0
School MD	8	3.2
Job physical	23	9.3
Gynecologist	25	10.1
Other	30	12.1
Total	248	100.0
4. Was blood pressure checked at last exam		
Yes	234	92.5
No	13	5.1
Don't know	3	1.2
Never had exam	3	1.2
Total	253	100.0
5. Was urine checked at last exam		
Yes	204	80.6
No	43	17.0
Don't know	3	1.2
Never had exam	3	1.2
Total	253	100.0
6. TB skin test or chest x-ray at last exam		
Yes	115	45.5
No	132	52.2
Don't know	3	1.2
Never had exam	3	1.2
Total	253	100.0
7. Hearing checked at last exam		
Yes	145	57.5
No	101	40.1
Don't know	3	1.2
Never had exam	3	1.2
Total	252	100.0

Table 65. continued

Category	Number	Percent
8. Eyesight checked at last exam		
Yes	160	63.5
No	86	34.1
Don't know	3	1.2
Never had exam	3	1.2
Total	252	100.0
9. Got advice from family planning service		
Never	171	67.6
In last 5 years	24	9.5
In last year	11	4.3
No, MD advised me	38	14.6
No answer	9	3.6
Total	253	100.0
10. When sick, how soon do you see MD		
Immediately	69	27.3
Wait a while	74	29.2
Put it off	47	18.6
Emergency only	62	24.5
Other	1	0.4
Total	253	100.0
11. Doctor ever refused to treat		
Never	233	92.1
Yes	20	7.9
Total	253	100.0
12. Why doctor refused to give treatment		
Didn't refuse	182	89.7
Too far away	1	0.5
On public aid	10	4.9
I missed appointments	2	1.0
Other reason	7	3.4
Don't know	1	0.5
Total	203	100.0
13. Want to talk to psychologist about nerves		
No	121	47.8
Yes	108	42.7
Go mental health	8	3.2
Go to Family and Children's Service	2	0.8
Private psychologist	13	5.1
Public drug rehab	1	0.4
Total	253	100.0

Table 65, continued

Category	Number	Percent
14. Regular family dentist or dental clinic		
No	92	36.5
Yes	160	63.5
Total	252	100.0
15. Time of last dental exam		
Never	2	0.8
More than 5 years ago	64	25.4
Less than 5 years ago	48	19.0
In last year	138	54.8
Total	252	100.0
16. Who did last dental exam		
Dentist	234	94.4
Hygienist	7	2.8
School checkup	2	0.8
Job physical	1	0.4
Other	4	1.6
Total	248	100.0
17. Delay seeing dentist		
No	107	43.5
Yes	139	56.5
Total	246	100.0
18. Eyesight checked, besides for license		
Never	26	10.4
More than 5 years ago	20	8.0
Less than 5 years ago	75	30.0
In last year	129	51.6
Total	250	100.0
19. Who checked eyes, not for license		
Ophthalmologist	101	42.4
Optometrist	79	33.2
Own MD clinic	22	9.2
Job physical	14	5.9
School	4	1.7
Other	3	1.3
Doesn't apply	15	6.3
Total	238	100.0
20. Wear glasses		
No	90	36.1
Yes	159	63.9
Total	249	100.0

Table 65. continued

Category	Number	Percent
21. Year of new glasses, of those who wear glasses		
Before 1970	6	4.2
1970-73	20	13.5
1974	21	14.2
1975	28	18.9
1976	54	36.5
1977	19	12.8
Total	148	100.0
22. Year of last getting glasses, of those who wear glasses		
Before 1970	5	3.5
1970-73	17	11.6
1974	22	15.0
1975	30	20.4
1976	56	38.1
1977	17	11.6
Total	147	100.0

	Percent of those who said yes
23. Reasons given by those who report delay in visiting physician (N=170)	
Fear or pain	7.6
Afraid of serious problem	20.6
Embarrassed by physical	15.9
MDs prejudiced against welfare	17.6
Religious reasons	1.8
Can care for self	71.2
Can't leave kids	14.1
Don't have use of car	24.1
There's no bus	12.9
Can't afford it	12.9
MD's hours inconvenient	5.9
Can't get MD	5.9
For other reasons	24.7

Table 65.continued

Category	Percent of those who said yes
24. When do you visit the dentist (N=218)	
For toothache	53.7
For decay or to fix filling	10.6
When gums are sore or bleeding	9.2
When have regular appointment	14.2
When want tooth pulled	48.2
Special scheduled treatment	28.9
For new dentures	23.9
For denture adjustment	22.5
For denture replacement	22.0
25. Reasons given by those who report delay in visiting dentist (N=141)	
No dentists accept Medicaid	10.6
Afraid he'll remove teeth	19.9
Until really seems needful	38.3
Can't leave children	9.2
Transportation a problem	9.2
Really afraid of going	57.4
Hours inconvenient for me	9.9
Trouble scheduling appointments	11.3
Too expensive	14.2
Other reasons	24.1

[a] Does not total 260 because of missing information

Table 66. Medical Problems at birth, total sample.

Diagnoses	ICDA Code	# clients
Other congenital anomalies of limbs	755	4
Other congenital anomalies of musculoskeletal system	756	4
Immaturity, unqualified	777	4
Ill-defined and unknown causes of morbidity and mortality	796	3

The following ICDA Codes were also diagnosed in 2 clients: 775, 776, 778.

The following ICDA Codes were also diagnosed in 1 client: 360, 370, 373, 379, 389, 424, 427, 486, 550, 741, 744, 750, 775.

Table 67. Medical Problems during preschool years, total sample.

Diagnoses	ICDA Code	# clients
Acute laryngitis and tracheitis	463	9
Asthma	493	7
Hypertrophy of tonsils and adenoids	500	6
Bronchopneumonia, unspecified	485	5
Streptococcal sore throat and scarlet fever	034	5
Strabismus	373	4
Pneumonia, unspecified	486	4
Appendicitis	541	3
Inguinal hernia	550	3

The following ICDA Codes were also diagnosed in 2 clients: 033, 269, 381, 785, 850, 949, 996.

The following ICDA Codes were also diagnosed in 1 client: 9.1, 10.0, 043, 055, 072, 215, 216, 265, 269, 287, 339, 370, 377, 379, 387, 389, 390, 464, 480, 493, 507, 521, 541, 551, 618, 680, 684, 692, 722, 735, 744, 746, 750, 754, 782, 783, 791, 803, 804, 812, 813, 814, 827, 865, 873, 884, 929, 942, 954, 989, 991.

Table 68. Medical Problems during school years, total sample.

Diagnoses	ICDA Code	# clients
Appendicitis	541	13
Anxiety depression	300	12
Acute tonsillitis	463	10
Hypertrophy of tonsils and adenoids	500	8
Strabismus	373	5
Pneumonia	486	4
Disorders of menstruation	626	4
Symptoms referrable to limbs and joints	787	4
Concussion	850	4
Benign neoplasm of buccal cavity and pharynx	210	3
Drug dependence	304	3
Special symptoms N.E.C. (includes sleep disorder)	306	3
Polyarteritis nodosa and allied conditions	446	3
Chronic bronchitis	491	3
Asthma	493	3
Infections of kidney	590	3
Vertebrogenic pain syndrome	728	3
Certain symptoms referrable to nervous system	780	3
Headache	791	3
Fracture of clavicle	810	3
Fracture of humerus	812	3
Fracture of carpal bone	814	3
Other ill-defined fractures of upper limb	818	3
Fracture of tibia and fibula	823	3
Open wound of knee, leg, except thigh and ankle	891	3
Injury, other and unspecified	996	3

The following ICDA Codes were also diagnosed in 2 clients: 001, 034, 070, 269, 277, 285, 303, 390, 507, 550, 690, 706, 724, 755, 802, 805, 816, 824, 945.

The following ICDA Codes were also diagnosed in 1 client: 008, 009, 016, 107, 021, 032, 033, 035, 041, 055, 077, 079, 110, 214, 219, 240, 245, 287, 289, 295, 301, 303, 311, 345, 347, 350, 374, 376, 378, 379, 384, 387, 389, 391, 393, 400, 424, 430, 455, 462, 465, 480, 504, 507, 511, 531, 533, 547, 551, 564, 575, 595, 625, 691, 692, 700, 706, 712, 722, 725, 729, 731, 745, 746, 755, 781, 783, 785, 787, 790, 803, 804, 807, 822, 826, 827, 828, 840, 882, 884, 910, 911, 922, 940, 945, 954, 962, 996, 998.

Table 69.Medical Problems since leaving school, total sample.

Diagnoses	ICDA Code	# clients
Neuroses	300	62
Vertebrogenic pain syndrome	728	43
Disorders of menstruation	626	35
Obesity	277	28
Essential benign hypertension	401	28
Symptoms referrable to limbs and joints	787	24
Alcoholism	303	19
Special symptoms N.E.C.(includes sleep disorders)	306	16
Cholelithiasis	574	16
Varicose veins of lower extremities	454	15
Headache	791	15
Hernia of abdominal cavity (excludes inguinal)	551	14
Symptoms referrable to respiratory system	783	14
Nervousness and debility	790	14
Drug dependence	304	13
Diabetes mellitus	250	11
Appendicitis	541	11
Spontaneous abortion	643	11
Menopausal symptoms	627	10
Eczema and dermatitis, NOS	692	10
Synovitis, bursitis, and tenosynovitis	731	10
Symptoms referrable to genitourinary system	786	10
Asthma	493	9
Disturbances such as convulsions, spasm, dizziness, memory loss	780	9
Infections of kidney	590	8
Displacement of intervertebral disc	725	8
Other diseases of the eye	378	7
Hemmorhoids	455	7
Hypertrophy of tonsils and adenoids	500	7
Disorders of function of stomach	536	7
Calculus of kidney and ureter	592	7
Infective diseases of uterus, vagina and vulva	622	7
Arthritis, unspecified	715	7
Symptoms referrable to abdomen and lower gastrointestinal tract	785	7
Injury, other and unspecified	996	7
Myxedema	244	6
Migraine	346	6
Ill defined heart disease	429	6
Chronic bronchitis	491	6

Table continues on following page.

Table 69. Medical Problems since leaving school, total sample (continued).

Diagnoses	ICDA Code	# clients
Peptic ulcer	533	6
Cystitis	595	6
Uterovaginal prolapse	623	6
Pre-eclampsia, eclampsia and toxemia	637	6
Osteoarthritis and allied conditions	713	6
Other diseases of joint	729	6
Other diseases of muscle, tendon and fascia	733	6
Other general symptoms (includes rash, weight loss)	788	6
Fracture of ankle	824	6
Superficial injury of trunk	911	6
Adverse effects of antibiotics	960	6
Benign neoplasm of ovary	220	5
Other diseases of ear (includes wax in ear)	389	5
Acute tonsillitis	463	5
Other diseases, upper respiratory tract	508	5
Diseases of hard tissue of teeth	521	5
Inguinal hernia	550	5
Functional disorders of intestines	564	5
Cholecystitis and cholangitis	575	5
Ectopic pregnancy	631	5
Delivery complicated by fetopelvic disproportion	655	5
Acute arthritis, pyogenic	710	5
Disturbances of vision, hearing and speech	781	5
Lipoma	214	4
Schizophrenia	295	4
Physical disorders presumably of psychogenic origin	305	4
Epilepsy	345	4
Phlebitis and thrombophlebitis	451	4
Chronic sinusitis	503	4
Ulcer of duodenum	532	4
Other diseases of urinary tract	599	4
Salpingitis and oophoritis, unqualified	614	4
Other congenital anomalies of limbs	755	4
Symptoms referrable to cardiovascular and lymphatic system	782	4
Sprains and strains, ankle and foot	845	4
Benign neoplasm, other female genital organs	221	3
Unspecified anemia	285	3
Strabismus	373	3
Hypertensive heart disease	402	3
Acute bronchitis and bronchiolitis	466	3
Viral pneumonia	480	3
Bronchopneumonia	485	3
Pneumonia, unspecified	486	3
Other hernia of abdominal cavity with obstruction	553	3

Table continues on following page.

Table 69.Medical Problems since leaving school, total sample (continued).

Diagnoses	ICDA Code	# clients
Cirrhosis of liver	571	3
Other diseases of liver (hepatitis NOS)	573	3
Stricture of urethra	598	3
Pelvic inflammatory disease	616	3
Other diseases of uterus	625	3
Diseases of sebaceous glands	706	3
Urticaria	708	3
Other diseases of bone	723	3
Other congenital anomalies of musculo-skeletal system	756	3
Fetal death of unknown cause	779	3
Fracture of face bones	802	3
Fracture, ribs, sternum and larynx	807	3
Fracture, tarsal, metatarsal bones	825	3
Sprains, strains, of back NOS	847	3
Contusion of hip, thigh, ankle, leg	927	3

The following ICDA Codes were also diagnosed in 2 clients: 112, 180, 182, 218, 234, 239, 240, 280, 281, 299, 370, 377, 380, 381, 387, 398, 492, 504, 520, 525, 535, 610, 611, 615, 620, 629, 634, 641, 642, 680, 685, 696, 698, 707, 712, 714, 730, 735, 800, 804, 813, 814, 816, 818, 823, 826, 827, 842, 881, 891, 959.

The following ICDA Codes were also diagnosed in 1 client: 111, 135, 151, 189, 213, 233, 269, 272, 273, 279, 287, 291, 294, 296, 298, 301, 302, 309, 350, 352, 357, 360, 379, 384, 403, 410, 424, 436, 443, 450, 462, 464, 465, 506, 507, 511, 523, 528, 530, 547, 552, 563, 577, 593, 597, 604, 607, 612, 618, 621, 624, 632, 644, 653, 654, 681, 682, 683, 690, 695, 700, 703, 714, 717, 737, 738, 740, 753, 758, 761, 762, 770, 775, 777, 789, 805, 810, 812, 821, 822, 836, 850, 865, 886, 907, 912, 916, 918, 921, 943, 944, 961, 965, 966, 970, 979, 996, 998.

Table 70. Diagnoses made at physical examination, intervention and control groups.

Diagnoses	ICDA Code	# clients
Neuroses	300	113
Obesity not specified as of endocrine origin	277	65
Alcoholism	303	30
Vertebrogenic pain syndrome	728	24
Diseases of hard tissues of teeth	521	22
Essential benign hypertension	401	20
Poor hygiene	---	19
Periodontal diseases	523	19
Other diseases of muscle, tendon, and fascia	733	14
Varicose veins of lower extremities	454	13
Personality disorders	301	12
Chronic bronchitis	491	12
Cirrhosis of liver	571	12
Mild mental retardation	311	9
Osteoarthritis and allied conditions	713	9
Symptoms referable to limbs and joints	787	9
Nervousness and debility	790	9
Other nutritional deficiency	269	8
Other hernia of abdominal cavity without mention of obstruction	551	8
Diabetes mellitus	250	7
Drug dependence	304	7
Diseases of sebaceous glands	706	7
Synovitis, bursitis, and tenosynovitis	731	7
Other congenital anomalies of musculoskeletal system	756	7
Refractive errors	370	6
Symptomatic heart disease	427	6
Ill-defined heart disease	429	6
Acute bronchitis and bronchiolitis	466	6
Other diseases and conditions of the teeth and supporting structures	525	6
Symptoms referable to respiratory system	783	6
Other eczema and dermatitis	692	5
Pruritus and related conditions	698	5
Other diseases of skin	709	5
Other diseases of joint	729	5
Curvature of spine	735	5
Benign neoplasm of skin	216	4
Borderline mental retardation	310	4
Asthma	493	4
Disorders of menstruation	626	4
Corns and callosities	700	4
Arthritis, unspecified	715	4
Displacement of intervertebral disc	725	4
Symptoms referable to cardiovascular and lymphatic system	782	4

Table continues on following page.

Table 70. Diagnoses made at physical examination, intervention and control groups, continued.

Diagnoses	ICDA Code	# clients
Other viral diseases	079	3
Physical disorders of presumably psychogenic origin	305	3
Other diseases of retina and optic nerve	377	3
Other deafness	389	3
Gastritis and duodenitis	535	3
Hallux valgus and varus	737	3
Other deformities	738	3
Certain symptoms referable to nervous system and special senses	780	3

The following ICDA Codes were also diagnosed in 2 clients: 110, 214, 274, 295, 297, 345, 346, 373, 379, 381, 424, 443, 455, 456, 686, 690, 695, 704, 781, 789, 791, 824, 881.

The following ICDA Codes were also diagnosed in 1 client: 009, 034, 044, 078, 097, 111, 132, 133, 134, 135, 206, 240, 244, 263, 265, 273, 278, 279, 280, 281, 282, 287, 291, 302, 306, 312, 347, 350, 352, 353, 357, 360, 378, 380, 384, 386, 387, 395, 402, 412, 451, 460, 461, 464, 492, 507, 522, 550, 564, 574, 610, 611, 621, 623, 624, 627, 629, 691, 705, 708, 710, 717, 723, 724, 726, 741, 746, 750, 755, 770, 772, 784, 785, 788, 805, 813, 814, 816, 827, 836, 845, 883, 916, 918, 923, 974, 990.

Table 71. Diagnoses found among clients who refused to participate after evaluation (22 clients)

Diagnoses	ICDA Code	% of clients
Obesity	277	31.8
Neuroses	300	22.7
Poor hygiene	---	13.6
Periodontal disease	523	9.1
Other dental conditions	525	9.1
Endometritis	622	9.1
Acute septic arthritis	710	9.1
Injury, other and unspecified	996	9.1

The following also were found in one client each (4.5%): 216, 278, 301, 311, 340, 346, 379, 381, 387, 491, 492, 493, 521, 551, 681, 746, 780, 781, 783, 787, 793, 819, 827, 996

Table 72. New diagnoses made at follow-up physical examination.

Diagnoses	ICDA Code	# clients
Symptoms referrable to respiratory system	783	6
Symptoms referrable to limbs or joints	787	6
Other diseases of joints	729	5
Nervousness and debility	790	5
Essential benign hypertension	401	4
Diseases of hair and hair follicles	704	4
Symptoms referrable to genitourinary system	786	4
Acute pharyngitis	462	3
Other diseases of stomach and duodenum	626	3
Disorders of menstruation	537	3
Symptoms referrable to upper gastrointestinal tract	784	3
Headache	791	3

The following ICDA Codes were also diagnosed in 2 clients: 627, 629, 699, 706, 710, 711, 715, 732, 781, 788.

The following ICDA Codes were also diagnosed in 1 client: 001, 003, 009, 034, 069, 132, 133, 138, 232, 251, 277, 278, 300, 301, 307, 369, 380, 455, 461, 465, 470, 480, 490, 503, 511, 532, 551, 564, 569, 572, 623, 631, 717, 780, 807, 836, 900, 997.

Table 73.

Summary of Current Diseases and Salient Antecedent Events in Medical History of Clients Who Were Not Accepted by CHRP for Active Intervention or Control Categories Because of Serious, Multiple Health Problems Not Deemed to be Remediable.

Sex	Age	Ithaca & Syracuse Current Diseases	Salient Antecedent Events in Medical History
F	35	organic brain damage hypertension mental retardation (acquired)	subarachnoid hemorrhage
M	24	schizophrenia undernutrition	
M	56	diabetes mellitus diabetic retinopathy chronic alcoholism Dupuytren's contracture	
M	24	antisocial behavior (in jail after referral)	concussion
F	37	delusional psychosis (schizophrenia)	in psychiatric care
F	50	obesity umbilical hernia varicose veins dermatitis edema	dermatitis
F	50	paranoid schizophrenia deafness	
F	47	arthritis of spine lumbar scoliosis polycythemia dyspnea	
F	33	hypochondriasis anxiety neurosis (severe) obesity epigastric hernia	alcoholic psychosis
M	28	confusional psychosis poor hygiene dental caries partially edentulous	constitutional psychopathology drug abuse (cocaine) since 1972 head injury

Table 73 continued.

Sex	Age	Ithaca & Syracuse Current Diseases	Salient Antecedent Events in Medical History
F	31	visual handicap - severe-bilateral (late effect of cataract surgery) vertebrogenic pain syndrome obesity	congenital cataracts
F	46	rheumatoid arthritis cystocele urinary incontinence obesity	arthritis incontinence - urinary congestive heart failure
F	40	urinary incontinence angina	heart disease
M	33	Kyphoscoliosis obesity dyspnea periodontal disease/dental caries	emphysema
F	41	mental retardation visual handicap vertebrogenic pain syndrome hypertension obesity	back problem "nerves"
M	40	late effects of pulmonary tuberculosis hypertensive heart disease pelvic tumor vertebroenic pain syndrome anxiety - depression hydronephrosis obesity	tuberculosis hypertension back problem
M	33	radiculopathy [requirement for neurological workup]	herniated, intervertebral disc
M	40	seizure disorder chronic carditis dental caries	rheumatic fever head injury seizure disorder - petit mal

Table 74. Present WIN status of Syracuse clients in intervention and control groups

Status Code	Status	Intervention clients		Control clients	
		N	%	N	%
105	Institutional training (WIN-funded)	1	2.7	0	0
107	CETA training	1	2.7	1	2.5
209	WIN PSE	0	0	1	2.5
301	Working registrant	3	8.1	1	2.5
801	Unassigned	7	18.9	5	12.5
802	60-day counseling	1	2.9	0	0
803	Job search	5	13.5	4	10.0
930	Employed after reg. off AFDC	2	5.4	2	5.0
940	Deregistered as exempt	13	35.1	18	45.0
945	Off AFDC - other	0	0	1	2.5
950	Sanctioned	2	5.4	7	17.5
Missing		17	--	14	--
		54		54	

APPENDIX D

CLIENT CASE RESUMES

ITHACA

SYRACUSE

Ithaca

- Female, age 25, head of household, 1 child, age 6; left school with a BOCES-Special Attendance diploma.
- Past Health History-allergic dermatosis, tubal ligation.
- Presenting Health Problem-stomach pain.
- Chief Physical/Psychological findings-borderline mental retardation; WAIS score 70; initial Hypochondriasis score 16, final score 8.
- Social Evaluation at initial-impaired learning ability, emotional immaturity, traumatic incident of being deprived of her family through personal tragedy, several crises including the husband's suicide.
- Social evaluation at final-client demonstrating social maturity, decision-making capabilities and had assumed virtually total responsibility for herself and her daughter.
- Current Welfare Duration-Five (5) years.
- Welfare Support at initial-$224.00, at final $180.35.
- Intervention-The client's response to psychological, job and social support counseling was excellent. She was also accepted for literacy training program. (58 contacts)
- Work History/Status-before coming to CHRP and up to six (6) months after intervention started, she had no job skills and was not employed. At the six (6) months' stage of intervention, she started working as a maid at $2.50/hr., still maintains this job, and is held in high regard by her employer.
- Finalstaff evaluation: CHRP was designated primary contact because of counselor availability and a total support system which was critical to success. CHRP was very effective in promoting employability and her job is considered to be permanent.

* * * * * * *

- Female, age 28, head of household, 2 children, ages 6 and 3; high school graduate.
- Past Health History-Fractured leg, juvenile arthritis, irregular menses and menstrual cramps, Cholecystitis, Migraines.
- Presenting Health Problem-Overweight.
- Chief Physical/Psychological findings-gross obesity, anxiety neurosis, thoracic-outlet syndrome. WAIS score 132, initial Hypochondriasis score 25, final score 20.
- Social Evaluation at final-She remained very nervous and emotionally immature. She did not engage in outside activities and lacked motivation for improvement of physical and emotional problems.
- Current Welfare duration - 4 years
- Welfare support at initial - $377.00, final $377.00.
- Intervention-Fairly cooperative for health education, unresponsive to weight reduction and psychological counseling after job counseling -rejected jobs offered; Pain still present in arm after consults with various doctors. (33 contacts)
- Work History/Status- held 6 different jobs from 1967-1973 doing farm work to nurses aide work. At initial and final contacts, she remained unemployed.
- Final Staff evaluation: She did not make progress on any of her goals and was non-compliant after a certain point. Because of her weight problem and persistant severe pain and anxiety, promoting employability in this case was not effective.

- Female, age 35, head of household, 5 children, ages 13, 12, 11, 8, 7. After graduating from high school, she completed two years of college.
- Past Health History-Colitis, Infectious Hepatitis, Pneumonia, Cholecystitis, Peptic ulcers, Chronic Bronchitis.
- Presenting Health Problem-Chronic Bronchitis
- Chief Physical/Psychological findings-Chronic Bronchitis and sick role behavior. WAIS score 105, initial Hypochondrias score 22, final score 12.
- Social Evaluation at initial-Personal (financial) problems, inability to find appropriate job, child care problems, welfare resentment, easily upset/angry.
- Social Evaluation at final-When she was working, she was extremely busy and happy at work and home. When not working, she became depressed. Her psychological status seemed directly related to her financial situation and employment.
- Current Welfare Duration-7 years.
- Welfare Support-at initial $498.00, at final 305.85.
- Intervention-A very good response to psychological and health education counseling was seen, with an excellent response to job counseling. (28 contacts)
- Work History/Status-In 1970 before coming to CHRP, she held 1 job for 3 months as a cashier. She was unemployed until 3 months after intervention was started at which time she became a cafeteria supervisor full time at $2.30/hr. At 6 months, she still maintained the same job with added responsibilities of retail manager. She received $3.21/hr. At the present time, she is a Nutrition Aide being paid $2.65.
- Final Staff evaluation-Because of her need to improve her financial situation but work at a job she enjoyed, this client had to be guided away from inappropriate work goals. After CHRP helped her obtain a job at which she was doing very well, her work potential was improving as home responsibilities diminished. CHRP was very effective in promoting employability.

* * * * * * *

- Female, age 31, head of household, 1 child, age 10; 11th grade education.
- Past Health History-Tonsillitis, Tonsillectomy, Chololithiasis, Cholecystectomy, back injury.
- Presenting Health Problem-back trouble.
- Chief Physical/Psychological findings-facial acne and neurosis. WAIS score 90, initial Hypochondrias score 10, final - missing because client refused follow-up.
- Social Evaluation at initial-Welfare institutionalized, emotionally unstable because of recent separation from husband and anti-social attitudes toward others.
- Social Evaluation at final-Client refused to return for 3-month evaluation, still welfare institutionalized.
- Current Welfare Duration-2 1/2 years.
- Welfare support at initial-$212.00, at final $212.00.
- Intervention-CHRP had started psychological, job, social and health education counseling which was rejected by client. (41 contacts)
- Work History/Status-held 3 different jobs in 3 years. After rejecting CHRP, she held a job as a teacher's aide for 2 weeks, but lost it because of her anti-social attitudes toward other aides and students.
- Final Staff evaluation-This client, being anti-social and not motivated toward rehabilitation or work, rejected CHRP and the referring agency was contacted. CHRP was not effective in promoting employability.

- Female, age 34, head of household, 2 children, ages 13, 7; 10th grade education.
- Past Health History-miscarriage, tonsillectomy, compound fracture, left ankle, 2 fingers broken on right hand, hysterectomy, herniated lumbar disc with removal or L-5 and F-1, wrist slashing and 3 drug overdoses.
- Presenting Health Problems-back problem, depression.
- Chief Physical/Psychological findings-deformity of 4th finger-right hand, late effects of back surgery, anxiety, depression. Beta score 105, initial Hypochondriasis score 15, final 14.
- Social Evaluation at initial-Problems with family relationships, child care, transportation.
- Social Evaluation at final -After obtaining her job, she had more self-confidence and when she came in for her 9 mo. follow-up, she had no new health problems. She found a daycamp and sitter for her children with CHRP help. She eventually was able to budget her income and buy a car which was needed for her job and transporting her children.
- Current Welfare duration-7 years.
- Welfare support at initial-$172.50, at final $0.00.
- Intervention-Evaluation and consultation regarding her back, staff support and job counseling with excellent response. (20 contacts)
- Work History/Status-Assembly line in 3 different factories, molecular research, and lab technician. At initial, she was unemployed. After 3 mo. intervention, she started working as a lens cleaner at $2.50/hr. and after 9 mo. was made Department Supervisor at $3.25/hr.
- Final Staff Evaluation-Highly motivated to work at initial and with the support and counseling of CHRP many of her problems were solved. CHRP was very effective in promoting employability and her job is considered to be permanent.

* * * * * * * *

- Female, age 32, head of household - 3 children, ages 12, 10, + 9 mos. (9 mos. old born after initial); high school graduate.
- Past Health History-Acute intermittent porphyria, dermatitis, pelvic cyst, spontaneous abortion with complications, salpingitis, tonsillitis, tonsillectomy, kidney infections.
- Presenting Health Problem-Dryness of hands, recurrent incapacitating illness.
- Chief Physical/Psychological findings-Obesity, dermatitis, acute intermittent porphyria. Beta score 108, hypochondriasis score initial 12, final 11.
- Social evaluation at initial-Very outgoing and vivacious. Motivated to find work. Would benefit from vocational counseling. Wants a good job so she can get completely off welfare. Interested in weight reduction.
- Social evaluation at final-Very happy, many personal problems cleared up after last child was born. Still needs weight reduction. Not employed.
- Current welfare duration - 3 years.
- Welfare Support at initial-$308.00, final $321.80.
- Intervention-Because of employment, weight reduction response was moderate, job, support, health education counseling had a good response. (26 contacts)
- Work history/status-Before coming to CHRP, she held 9 different jobs in 4 years as either a waitress or secretary. At initial contact, she was unemployed. At 3 months she was a waitress part-time. At 6 months, she was enrolled in a CETA secretary course. At 9 months, she returned to the snack bar as manager $3.00/hr. At final evaluation - unemployed with 9 month old son.
- Final Staff evaluation-Client still overweight and with a 9 month old son which impedes employment. School contacts and enrollment were through CHRP. CHRP was moderately effective in promoting employment.

- Female, age 26, head of household, 1 child, age 2; high school graduate.
- Past Health History-Tonsillitis, tonsillectomy, back problem.
- Presenting Health Problem-Physical exam requested by referring agency.
- Chief Physical/Psychological findings- poor muscle tone, minor hemorrhoids, back problem. Beta score 108, initial Hypochondrias score 4, final score 4.
- Social Evaluation at initial-difficulty in relating to people, inability to locate job, lack of job skills and training, difficulty in gaining custody of two children who lived with ex-husband.
- Social Evaluation at final-In the 6 months following her initial involvement with CHRP, she had two part-time jobs, had remarried, was off public assistance and seemingly very happy.
- Current Welfare duration-18 months.
- Welfare support at initial-$250.00, final $0.00.
- Intervention-Responded to back evaluation and therapy sessions with CHRP support. Missed several psychological counseling sessions. (10 contacts)
- Work History/Status-Before coming to CHRP, her last year of employment was 1973. Before 1973, she held 6 different waitress and secretarial jobs. At her initial appointment, she was unemployed. At 3 months, she worked part-time as a sales girl and at 6 months, she added a second part-time waitress job ($2.30/hr. - $1.65/hr.). At final evaluation, she also added a third job as a companion which gave her $100/week.
- Final Staff Evaluation-Because of her motivation to work and the counseling received from CHRP, she was able to purchase a bicycle for exercise and transportation and find daycare for her child. She was able to cope with people in her job and community. In the future, she may refresh her secretarial skills. CHRP was very effective in promoting employability.

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- Female, age 42, head of household, 1 child, age 15; 10th grade education.
- Past Health History-recurrent colds, viral pneumonia, leg cramps.
- Presenting Health Problem-Physical exam requested by referring agency.
- Chief Physical/Psychological findings-neurosis. Beta score 103, initial Hypochondriasis score 12, final score 4.
- Social Evaluation at initial-Lacked confidence, inability to find job, lonely, lacked involvement and contacts with others, recent separation, problem dealing with being single and independent and a daughter with behavorial problems.
- Social Evaluation at final-Working involvement with local politician helped to improve her typing skills and overcome several personal problems re: separation and to improve her self-concept. Continued to have difficulty with her daughter.
- Current Welfare duration-5 months.
- Welfare Support at initial-$212.00, at final $0.00.
- Intervention - This client's approach to psychological support and job counseling was excellent. All long and short term goals were approached or reached. (58 contacts)
- Work History/Status-She held 2 jobs in 7 years working as an office clerk. At initial, she was unemployed. At 3, 6 and final evaluations, she had been employed as a secretary and receptionist doing general office work at local health programs and hospital.
- Final Staff Evaluation-She was very cooperative with CHRP. Skills were upgraded through recommended volunteer job, and self-confidence generally improved. CHRP was very effective in promoting employability.

- Female, age 23, head of household, 2 children, ages 2 and 3; 9th grade education.
- Past Health History-vaginal yeast infections, peptic ulcer, appendectomy, tubal ligation.
- Present Health Problem-Cough.
- Chief Physical/Psychological findings: acute bronchitis, emotional problems, peptic ulcer. Beta score 99, initial Hypochondriasis score 7, final 4.
- Social Evaluation at initial - At the time of initial, she was involved in group and individual counseling in a drug rehab. program. She lacked education and job skills. Conflict between client and her mother.
- Social Evaluation at final-Because of CHRP involvement, she was able to obtain a job and become more open and more enthusiastic about making some positive changes in her life.
- Current Welfare duration-3 years.
- Welfare Support at initial-$350.00, final $0.00.
- Intervention-Evaluation of peptic ulcer, support, job, health education and psychological counseling responses excellent. Rehab. concurrent at both CHRP and drug rehab. program. (17 contacts)
- Work History/Status-before coming to CHRP, her last job was in 1974. She had 2 different secretarial positions and a nurse's aide job (all 3 jobs combined lasted 8 months.) From 3 mo. evaluation to end of 6 month evaluation, she was employed for $3.00/hr. as a laborer in a factory, (then layed off) at final evaluation, she was a secretary with CETA, Job Training for $2.65/hr.
- Final Staff Evaluation- Because of her excellent response to counseling rehabilitation and the motivation for employment, CHRP found her easy to work with and a good prospect for continued future employment. CHRP was very effective in promoting employability.

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- Female, age 37, head of household, 2 children at initial, ages 11, 13; at final, 3 children - baby born in January'78; 10th grade education.
- Past Health History-Coma from diphtheria, goiter, migraine, auto accident-lacerations, whiplash, broken blood vessels in right ankle.
- Presenting Health Problem-Migraine.
- Chief Physical/Psychological findings-Varicose veins, mild dermatitis, low vital capacity, migraine, anxiety. Beta score 116, initial hypochondriasis score 15, final 10.
- Social Evaluation at initial-Client felt isolated living in the country with transportation and child care problems although enjoyed living in the country. She was reserved, intelligent, clinging and insecure.
- Social Evaluation at final-Unemployable because of new baby at home, still isolated with child care problem.
- Current Welfare duration-7 months.
- Welfare support at initial-$200.00, final $155.00 plus unemployment benefits.
- Intervention-Had surgical consultation regarding varicose veins and pain in right arm, excellent response to job counseling . (9 contacts)
- Work History/Status-Last job was in 1975. She had worked for 7 years at 5 different jobs, 3 as cashier, 1 in book bindery, and 1 as folder in linen company. At 3 and 6 months' follow-ups, she worked on assembly line for $3.00/hr. At final, she was unemployed because of lay-off at factory.
- Final Staff evaluation- Because of lay-off and pregnancy, motivation to work may be questionable. CHRP was very effective in promoting initial employability.

- Female, age 27, head of household, 2 children, ages 4, 5; high school graduate.
- Past Health History-strabismus, depression.
- Presenting Health Problems-Physical exam requested by referring agency.
- Chief Physical/Psychological findings-Under nutrition, Photophobia, anxiety-depression, acne, dental caries. Beta score 106, Hypochondriasis at initial 23, final 9.
- Social evaluation at initial-Extremely self-conscious, afraid of others, and quite confused about her personal needs and feelings.
- Social evaluation at final-She gradually gained confidence in herself; her personal appearance improved; became more involved with outside interests, established friendships and overcame her fear of others.
- Current Welfare duration-3 1/2 years.
- Welfare Support at initial-$355.00, final $231.80.
- Intervention-With the combined efforts of CHRP and the referring agency, the client's responses to health education, dental treatment and psychological counseling were excellent. The client was counseling re: employment, had some job interviews but was not ready for employment (35 contacts)
- Work history/status-Before 1975, she had held 4 different secretarial and factory jobs in 4 years. At initial, 3 months, and 6 months, she stayed unemployed. At the final evaluation, she became funded by OVR for a 4-year program at Wells College.
- Final Staff Evaluation-With the total support of CHRP and the referring agency, her self-image improved with counseling and she was guided into college which makes her prospect for future employment excellent.

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- Male, age 30, head of household, with 3 children, ages 5, 7, 11; 5th grade education.
- Past Health History-Strabismus, fracture of left wrist, laceration over right eye, abdominal injury.
- Presenting Health Problem-Injuries from recent auto accident.
- Chief Physical/Psychological findings-post-traumatic nerve injury, visual disability (amblyopia - right eye), mental retardation, alcoholism with liver disease. Beta score 74, hypochondriasis score initial 3, final 4
- Social evaluation at initial-Congenial, cooperative and quiet. Had good resources and was mildly retarded both intellectually and culturally. Motivated to find work, most likely to succeed in unskilled labor.
- Social evaluation at final-As more personal problems developed, this client returned to drinking. His children were unexpectedly taken out of state by his wife. He lost his job and became depressed. Expressed interest in learning to read and write and is still looking for employment.
- Current Welfare duration-5 years
- Welfare support at initial-$389.60, final $224.00.
- Intervention-He was very cooperative during job, psychological, health education and rehabilitation counseling. Alcohol counselling was accepted by him for 3 months at which time he had some personal problems and he could not find a job and became very depressed. (142 contacts)
- Work history/status-Year of last job - 1976. Previous employment - 6 years employed as a lumberjack and custodian. At initial, he was unemployed. Had a total of 16 job interviews, including jobs for one day to jobs lasting for 23 days. The duration of these jobs made him more motivated to find the right job but also it made him drink more. CHRP, at his request, contacted a previous employer. At 6 months, he stopped drinking with Antabuse R_x, employed in Salt Mines at $5.02/hr. At final, he was unemployed but looking for work.

- Final Staff evaluation-Because of family crisis, this client lost his job and subsequently returned to alcohol. Recently, he was in a detox unit and now in A.A. There is high motivation to return to work. CHRP was very effective in promoting employability.

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- Female, age 30, head of household, 1 child - age 9 and 1 child age 11 who after initial interview, was placed in a foster home; 11 1/2 years of school.
- Past Health History-tonsillitis, tonsillectomy, deafness, blindness, obesity, umbilical hernia, arthritis, urethral block, sinusitis.
- Presenting health problem-Obesity.
- Chief Physical/Psychological findings-Obesity, limitation of movement-left ankle, knock knees, scarring tympanic membrane, visual defect - right eye, sick role behavior. Beta score 110, hypochondriasis score-initial 21, final 11.
- Social evaluation at initial-Social problems with 11 yr. old daughter. Had transportation and child care problems. Her arthritis limited her movement which was compounded by her weight.
- Social evaluation at final-11 yr. old still undergoing psychological counseling and in a foster home. Client still lacks transportation and employment.
- Current welfare duration-5 years.
- Welfare support at initial-$16.80, final, $39.00.
- Intervention-Her response was very cooperative to evaluation of knees, eyes and job counseling . Her response to weight reduction was fair. (34 contacts)
- Work History/Status-Her last job before initial was in 1975. She had held 31 part-time maid and teacher's aide jobs for 2 years. At initial interview through 3 months, she was working part-time as a teacher's aide. At 6 months, she took a secretarial course and had a CETA receptionist job for the summer. At final evaluation, she was unemployed.
- Final Staff evaluation-Still in need of weight reduction. Still actively seeking employment. Prospect good for CETA job. CHRP was moderately effective in promoting employability.

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- Female, age 42, head of household with 2 children, ages 9, 15 at home and a 19 yr. old in college; High school graduate with 1 year of college.
- Past Health History-Pain in stomach identified as nerves, cholesystitis, cholecystectomy, back pain, laminectomy, breast biopsy, abdominal pain.
- Presenting Health Problems-Overweight.
- Chief Physical/Psychological findings-Obesity, limited mobility spine, spastic colon. Beta score 117, hypochondriasis score initial 6, final 4.
- Social evaluation at initial-Very outgoing but needed weight reduction to eliminate other health problems. Realized the need of better paying job.
- Social evaluation at final-Moved to New Jersey to a better job. Weight loss of over 30 lbs. Motivated to improve self and family.
- Current welfare duration-6 years
- Welfare support at initial-$118.55, final $0.00.
- Intervention-Very good response to weight reduction and consult and rehabilitation re: her back. (17 contacts)

- Work history/status-Employed 13 years full time and 4 years part-time as office clerk, saleswoman, laundry worker, secretary and nutrition aide. At initial, she was making $3.50/hr. as a nutrition aide, at 3 months, she moved to New Jersey as a bookkeeper and Salvation Army Program Coordinator.
- Final Staff evaluation-Client needed very little help with employment because she had the motivation. Insights into weight reduction and the loss of 30 plus pounds definitely increased her potential for longevity of employment. CHRP was moderately effective in promoting employability.

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- Male, age 26, head of household, 1 child age 5; 10th grade education. High school equivalency received 4/77.
- Past Health History-tonsillitis, tonsillectomy, crooked legs, dental caries, acute bronchitis, right knee injury.
- Presenting Health Problems-physical exam requested by referring agency.
- Chief Physical/Psychological findings-crepitus right knee, dental caries. Beta 106, hypochondriasis score initial 1, final 1.
- Social evaluation at initial-Pleasant, friendly and cooperative. Motivated to find work but had difficulty in defining his work goals.
- Social evaluation at final-Client expressing better decision making capabilities and interest in printing as a career.
- Current welfare duration-16 months.
- Welfare support at initial-$270.00, final $0.00.
- Intervention-Cooperative during knee consultation, dental treatment, and job counseling. (10 contacts)
- Work History/Status-employed 3 years and held 6 different jobs. At initial he was unemployed. At 3 months - janitor $2.35/hr, 6 months - different janitorial job - $2.35/hr. at final lithographer in New York City.
- Final Staff evaluation-Outlook good for continued employment. CHRP was moderately effective in promoting employability.

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- Female, age 26, at initial-head of household-now married. 3 children, 4, 7, 8. Went through 12th grade, did not graduate.
- Past Health History-Injury to face, sight poor in right eye, muscle spasms, laceration left hand, back injury.
- Presenting Health Complaint-headaches, bad teeth.
- Chief physical/psychological findings-Sick role behavior, râles both lung fields, periodontal disease, perineal warts, abdominal tenderness (retroverted uterus), late effects of injury left hand, lordosis. Beta 106, hypochondriasis at initial 19, final 15.
- Social Evaluation at initial-Very isolated and withdrawn with no friends and had been disowned by her family. She is anti-social and has persecutory ideas. Youngest child's father is in prison and she feels threatened and hostile.
- Social Evaluation at final-Married boyfriend while he was in prison, moved out of the county when he was released. Having some family readjustment problems also community adjustment problems. More outgoing, has several friends.
- Current welfare duration-2 1/2 years
- Welfare Support at initial-$233.45, final $0.00 (moved out of county)

- Intervention-Cooperative during back evaluations, and job counseling; good response to psychological counseling; responsive during health education and support; dental treatment, fair response. (161 contacts)
- Work History/Status-Before 1975 she held 10 different jobs in 3 years. Jobs include waitress, cashier, saleslady, typist, laborer. At initial she was unemployed. At 3 months, she took a CETA Secretarial course which was dropped after 1 month because of health and family problems. At 6 months, she was unemployed and had moved at final.
- Final staff evaluation-Intact family was of primary importance to this client. Became outgoing and stood up for herself as a person. She intends to involve herself in husband's business. CHRP was moderately effective in promoting employability.

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- Female, age 45, head of household, 1 child, age 13; 6th grade education.
- Past Health History-Tonsillectomy, asthma, diabetes mellitus, hypertension, varicose veins.
- Presenting Health Problem-overweight.
- Chief Physical/Psychological findings-Obesity, diabetes, dermatitis, varicose veins. Beta 106, hypochondriasis at initial 3, final 4.
- Social Evaluation at initial-psychological problems with youngest son made her afraid to leave home and go to work, poor hygiene, confused, timid, sensitive, lack of motivation.
- Social Evaluation at final-Still overweight but more out-going, moved out of county to be closer to relatives.
- Current Welfare duration-12 years.
- Welfare Support at initial-$307.00, final $0.00 (moved out of county)
- Intervention-Good response to weight reduction, diet counseling and health education. Cooperated with EKG consultation.(13 contacts)
- Work History/Status-Last year of employment was 1955. She had been employed at 1 job for 7 years as a maid and 1 year as a chicken cleaner. She has not been employed since.
- Final Staff evaluation-This client moved after the 3 month evaluation. CHRP was not effective in promoting employability because she moved and did not receive the 6 months' rehabilitation required before job or job training could start.

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- Female, age 26, head of household, 3 children, 8, 7, 5; 11th grade education
- Past Health History-Fractured right elbow, depression, attempted suicide, menorrhagia.
- Presenting Health Problem-Nervousness, under nutrition.
- Chief Physical/Psychological findings-Undernutrition, acute depression, late effect of injury right elbow, impaired learning ability, impaired memory. Beta score 72, hypochondriasis score initial 15, final 1.
- Social evaluation at initial-Hostile and belligerent toward others, fought easily, felt a lack of control over anger. Recent separation from boyfriend resulted in overdose of pills (self-destructive tendencies.)
- Social evaluation at final-Emotionally more stable and well-adjusted, on going support and advocacy recommended to maintain this position. Living with mother out of county and gaining small amount of weight.
- Current welfare duration-9 years.
- Welfare support at initial-$438.00, final $0.00 (moved out of the county)

- Intervention-Good response to nutrition, diet, psychological, health and job counseling. Cooperative response to social support. (34 contacts)
- Work History/Status-She worked in a factory for 6 months, nurse's aide 6 months and teacher's aide 5 1/2 years. Unemployed at initial and 3 months' follow-up. At 6 months, she was employed as a teacher's aide, CETA $2.30/hr. Unemployed at final.
- Final Staff evaluation-Prospect of employability guarded pending client's achievement of emotional and social stability. Health had improved. CHRP was moderately effective in promoting employability.

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- Female, age 29, head of household at entry, 2 children - ages 6, 8; high school graduate.
- Past Health History-irregular menstruation, tonsillitis, tonsillectomy.
- Presenting Health Problems-obesity.
- Chief Physical/Psychological findings-Obesity, poor hygiene. Beta score 103, hypochondriasis score initial 2, final 13.
- Social Evaluation at initial-recently separated from husband who offended her in public and would not take an active part in the family. Emotionally upset because of sexual assault on one of her children by husband's best friend.
- Social Evaluation at final-reunited with husband and working together as a family.
- Current Welfare duration-5 months.
- Welfare Support at initial-$158.00, final $0.00.
- Intervention-Passive rejection to weight reduction and health education. Good response to job and support counseling. (29 contacts)
- Work History/Status-She held 3 different jobs during 5 years of employment as a custodian and a chick servicer at two different poultry farms. Unemployed at initial, at 3 months employed as a saleswomen -$2.35/hr., 6 months - cashier - $2.35/hr. and at final, nurse's aide at $2.61/hr.
- Final Staff evaluation-Very happy working with people and being together with her family. Well suited to present job. CHRP very effective in promoting employability.

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- Male, age 28, head of household, 2 children - ages 3, 4; 10th grade education.
- Past Health History-Asthma, self-inflicted injury to forehead and left forearm, inguinal hernia.
- Presenting Health Problem-prior history of alcoholism.
- Chief Physical/Psychological findings-alcoholism, late effects of injury to left forearm, dental caries, periodontal disease, inguinal hernia. Beta score 106, hypochondriasis score - initial 5, final - client failed to respond for follow-up.
- Social Evaluation at initial-Client had health-related employment concern, personal and family problems. Left wife several times because of marital problems.
- Social Evaluation at final-Client still drinking and doing occasional short jobs. Divorced, failed to respond to CHRP for follow-ups.
- Current Welfare Duration-4 years.
- Welfare Support at initial-$94.00, final P.A. pending.

- Intervention-The client's response to consultation re: arm, psychological counseling, consultation re: hernia, dental referrals, health education, alcohol counseling, job counseling was total rejection.
- Work History/Status-He held 4 different jobs as dishwasher, bailer, garbage man, and punch press operator. He lost 3 jobs because of alcoholism. Has only had very short term employment since.
- Final Staff Evaluation-This client failed to try to let us help him or to help himself. He totally rejected CHRP.

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- Female, age 30, head of household, 4 children - 13, 12, 11, 10; 9th grade education.
- Past health history-burns to both feet, weight gain, backache, spontaneous abortion, D & C, tubal ligation, and arthritis right hand.
- Presenting Health problems-overweight
- Chief physical/psychological findings-obesity, dental caries, impaired postural mobility. Beta score 87, hypochondriasis initial 9, final 11.
- Social Evaluation at initial-Appeared to be a well-adjusted, easygoing, happy person with motivation to keep working and upgrade job skills.
- Social Evaluation at final-Still overweight, happy, likes her work.
- Current welfare duration-13 years.
- Welfare support at initial-$286.25, final $247.10.
- Intervention-Client's employment at time of initial was a conflict with weight reduction and health education classes. She did attend when she could. (8 contacts)
- Work History/Status-Employed 8 1/2 years, held 4 different jobs, teacher's aide, cashier, nurse's aide, and short order cook. Initial-three; final teacher's aide, started at $2.35/hr. final $2.75 plus overtime.
- Final staff evaluation-Client really liked her job working with children and will continue this form of employment which seems permanent. Because of initial employment CHRP did not have to promote employability.

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- Female, age 29, head of household - no children; high school graduate, 1 year of college.
- Past Health History-Tonsillectomy, pleurisy, rosacea, vaginal moniliasis, sprained thumb.
- Presenting health problem-overweight.
- Chief physical/psychological findings-Rosacea, obesity, anxiety state, hallux valgus, intertrigo. Beta score-11.7, hypochondriasis initial 3, final not administered (moved out of county).
- Social evaluation at initial-Client was pleasant and friendly but was tense and depressed. Recent split-up with boyfriend resulted in emotional problems.
- Social evaluation at final-dual counseling with referring agency focused on personal problems. This client moved before 3-month follow-up was done.
- Current Welfare duration-2 years
- Welfare Support at initial-$97.00, final $0.00 (moved out of county).
- Intervention-Group counseling, health education, weight reduction response was fair for amount of time in project. (6 contacts)
- Work History/Status-in 8 years, she held 14 different jobs full-time and part-time. Clerical, factory, saleslady, waitress, barmaid, test tube molder, nursing assistant training program, amusement park ride operator and microfilming.
- Final Staff evaluation-Good prospect for employment in future.

- Female, age 29, head of household, no children; high school graduate plus two years of college.
- Past Health History-respiratory disability, hyperventilation, pilonidal cyst, fractured ulna, alcoholism, contusion left eye.
- Presenting Health Problem-Alcohol abuse, undernutrition.
- Chief physical/psychological findings-Alcoholism with hepatitis, acute depression with psychosis, drug abuse, malnutrition. Beta was not administered due to influence of alcohol, drugs. hypochondriasis initial 22, final 7.
- Social Evaluation at initial-Client felt very out of control of her life, very paranoid and had delusions of persecution. Quite phobic and terrified of being alone. Excessive alcohol and drug abuse.
- Social evaluation at final-After the accepted residency in a drug rehabilitation facility for 8 months, she is now independent, in good health, employable, still in counseling with an excellent future.
- Current Welfare duration-2 1/2 years.
- Welfare support at initial-$140.00, final $0.00.
- Intervention-After health and psychological counseling re: abuse of drugs and alcohol, her response towards further counseling was excellent (21 CHRP contacts)
- Work History/Status-Before coming to CHRP, she held 9 jobs between 1967 and 1976. At initial and until 9 months, she was unemployed. At final, she was employed as a maid $2.65/hr.
- Final Staff evaluation-Through combined efforts of the client and other agencies, this client is independent and healthy. She now seeks white collar employment and will continue alcohol counseling on out-patient basis.

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- Male, age 25, head of household, no children; high school graduate.
- Past Health History-anemia, inguinal hernia, depression.
- Presenting Health Problems-nervousness.
- Chief Physical/Psychological findings-Mild mental retardation, depression, emotional immaturity. Beta score 70, hypochondriasis initial 10, final 3.
- Social evaluation at initial-Seemed quite tense and had personal problems. Sexually preoccupied, self-accusatory, very lonely, isolated, but motivated to find full-time employment.
- Social evaluation at final-Work habits and self-esteem greatly improved.
- Current welfare duration-3 years.
- Welfare support at initial-$209.00, final $209.00.
- Intervention-Good response to psychological and support counseling, sporatic response to job counseling. (19 contacts).
- Work History/Status-Held 4 different jobs from 1974-1976. Unemployed from initial through end of 9 months. At final, he was a janitor on work relief.
- Final Staff Evaluation-Work relief may become CETA job training. Has potential for competitive entry level employment. CHRP was moderately effective in promoting employability.

- Female, age 30, head of household, 3 children- 7, 8, 9; 10th grade education.
- Past Health History-Tonsillitis, tonsillectomy, cancer of the cervix, ovarian and tubal infection, oophorectomy, salpingectomy, stricture of ureter and repair, cystitis, vaginitis.
- Presenting Health Problem-Physical exam requested by referring agency.
- Chief Physical/Psychological findings-Sick role behavior, partially edentulous (lower), anxiety-depression. Beta score 103, hypochondriasis-initial 25, final 7.
- Social Evaluation at initial-Separated, feels threatened by ex-husband. Living with a man of a different race which was a source of conflict due to opinions and prejudices of others including parents. Motivated to find worthwhile employment.
- Social Evaluation at final-Received high school equivalency, took college courses to improve education, failed all but 1 course due to personal health, children's health and transportation problems. Bought a car and found a full-time job, motivated to get off welfare.
- Current welfare duration-20 months.
- Welfare support at initial-$374.00, final $277.85.
- Intervention-Excellent response to job and school, social support, psychological counseling, and health education which facilitated understanding of sick role behavior. (57 contacts).
- Work History/Status-As of 1977, she held 4 jobs totaling 7 years employment. Types of jobs were waitress, maid, assembly worker, and school bus chaperone - part-time. At initial, she was working on the bus, 3, 6 months CETA schooling. Present assembly at book bindery $2.75/hr.
- Final Staff Evaluation-Successful at job, employment seems permanent, has matured. CHRP was very effective in promoting employability.

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- Female, age 32, head of household, 2 foster children (nephews), 6, 7; high school graduate.
- Past Health History-back injury (automobile accident), eczema.
- Presenting Health Problem-Overweight.
- Chief Physical/Psychological findings-Obesity, dermatitis of hands and feet, anxiety depression, poor hygiene. Beta score 113, Hypochondriasis initial 7, final 3.
- Social Evaluation at initial-client was isolated and depressed but motivated to help herself. Under stress and tension at home concerning husband's terminal illness and adoption of two nephews, financial problem.
- Social Evaluation at final-Husband died, getting social security benefits, in college and motivated to do well, adoption very hopeful.
- Current Welfare Duration-1 1/2 years.
- Welfare Support at initial-$236.00, final $0.00 (moved out of county)
- Intervention-Excellent response to support and job counseling, good response to health education and psychological counseling. Did not attend in-house weight reduction. (31 contacts)
- Work History/Status-She worked 6 years full time and 5 years part-time as file clerk, sales, and cashier. Before coming to CHRP, she was laid off and cared for husband. At 6 months, she had applied for college, at final, she had moved and enrolled at a state college in New York.
- Final Staff Evaluation-Excellent prospect for realization of long-term goal - graduation and high level employment. CHRP was very effective in promoting education for employability.

- Male, age 25, head of household, 2 children - ages 2, 1; 9th grade education
- Past Healtn History-nodules on skin, breathlessness, pain in right eye, back problem, stomach pain.
- Presenting Health Problem-Extreme facial blemishes.
- Chief Physical/Psychological findings-Brooke's disease, (Trichoepithelioma), conjunctivitis, dental caries, poor hygiene, anxiety depression. Beta score 99, hypochondriasis initial 13, final 5.
- Social evaluation initial-Client had personal family problems, lack of self-esteem, nervousness/depression, employment problems with co-workers because of facial problem and socially isolated.
- Social evaluation at final-At case closure, he had made significant improvements and had several setbacks as well. Progress seems to depend on his emotional state which fluctuates. After plastic surgery, he was very happy and motivated to find employment.
- Current welfare duration - 3 years.
- Welfare support at initial-$449.00, final $449.00.
- Intervention-This client's response to dermatology treatment, plastic surgery, psychological, dental, job, health education and social support counseling was excellent. Very cooperative, interested in helping himself and his family. (96 contacts)
- Work History/Status-Between 1971-1975, he was employed for a total of 11 months in 5 different jobs -- carpenter, mechanic, laborer, garbage truck driver, and in the Marines (27 days). At initial, he was unemployed. At 6 months' fo[illegible]-up, he was employed as a roofer part-time at $8.00/hr. At final, he was unemployed.
- Final staff evaluation-Self-concept improved, health improved. Prospect for employment guarded, further advocacy indicated along with job training. CHRP was moderately effective in promoting employability.

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- Male, age 28, head of household, no children; high school graduate.
- Past Health History-Foot abnormality, astigmatism right eye, renal calculi, dental decay and complete dental extraction.
- Presenting Health Problem-emotional problems.
- Chief Physical/Psychological findings-emotional immaturity, poor muscle tone, poor hygiene, stratismus right eye, falsetto voice, insect bites. Beta score 92, hypochondriasis at initial 1, final 2.
- Social evaluation at initial-This client had poor hygiene, and looked quite effeminate and had a very high voice which made him more insecure and unexceptable in the type of employment he sought.
- Social evaluation at final-Very motivated to work after working on interviewing skills (personal appearance and presentation). He became involved in body mechanics and physical fitness at CHRP and YMCA. His coping mechanisms improved and he was less sensitive and excitable. He is now happy and coping adequately with his personal problems.
- Current welfare duration-17 months.
- Welfare support at initial-$203.00, at final $0.00.
- Intervention-This client's response to health education, psychological and job counseling, physical fitness, support counseling was very good. (16 contacts)

- Work History/Status-He had been employed for 5 years at 5 different jobs such as bookkeeper, mail sorter, stock boy, maintenance. At initial, he was unemployed, 3 months, he worked at Social Services as a CETA job training as an accountant $2.30/hr. At 6 months, he was an accountant, under CETA at the county hospital. At final, he returned to DSS as an accountant clerk for Medicaid unit at $2.65/hr.
- Final Staff Evaluation-This client requires a supportive work atmosphere. He requested through CHRP and CETA to return to DSS and work. Outlook excellent for continued employment at DSS if funds available to make job permanent. CHRP was very effective in promoting employability.

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- Male, age 23, head of household, no children; high school graduate, 1 year college.
- Past Health History-meningomyelocele, cartilage injury right knee.
- Presenting Health Problem-Physical exam requested by referring agency.
- Chief Physical/Psychological findings-Multiple congenital anomalies of spine, systolic murmur, anxiety depression, medial cartilage right knee. Beta score - 131, hypochondriasis initial 4, final 3.
- Social evaluation at initial-Felt depressed and anxious about break up with girlfriend, felt he was becoming self-destructive. He had unfulfilled ambitions, unable to locate job in his field-construction technology.
- Social evaluation at final-After counseling involvement, he became less depressed but he was constantly debating and refuting counsellor during group presentations. Motivation very high towards new employment and future.
- Current Welfare duration-6 months.
- Welfare Support at initial-$150.00, final $0.00.
- Intervention-Good response to health, job and psychological counseling, (7 contacts)
- Work History/Status-He had been employed a total of 18 months between 1970 and 1976 as a stocker, house painter, cabinet maker, driver. At initial, he was unemployed, 3 months, he was employed part-time as a cook, 6 months - Assistant Manager trainee at same business establishment, at final-he was a full-time draftsman ($150.00/wk.).
- Final Staff Evaluation-At initial, he had applied for a draftsman job at a local industry but was rejected because of lack of experience. Because of his aversive feelings toward welfare, his motivation for employment did not falter. He was very self-confident, back with his girlfriend and employed as a draftsman and when his finances will allow, he will return to college at night to upgrade his education. CHRP was moderately effective in promoting employability.

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- Female, age 21, head of household, no children; high school graduate, 1 year Vocational training.
- Past Health History-Rh incompatibility, dental decay, fractured right patella, recurrent dislocation of both knees, depression, 2 attempted suicides.
- Presenting Health Problem-overweight.

- Chief physical/psychological findings-gross obesity, pyoderma, recurrent dislocation of both knees, anxiety-depression. Beta score 116, hypochondriasis initial 16, final (not available - rejected CHRP).
- Social Evaluation at initial-Very nervous and depressed because she wants a better job and wants to get married. Very bored with present work relief job, wants extra schooling but financially can't afford it and is going to mental health for counseling. Seems to burden herself with worry and conflicts in a self-destructive manner.
- Social evaluation at final-Married, financial problems still a burden and much worry to her. Still overweight, now employed as laborer in a factory, did not complete extra vocational training course.
- Current welfare duration-3 years.
- Welfare Support at initial-$224.00, final $0.00 (did not re-certify)
- Intervention-Did not respond to weight reduction, physical therapy, individual or group counseling or health education. (no contacts)
- Work history/status-Last year of employment was 1974. Employed in 1973-74 for 15 months at 7 different jobs. 5 waitress jobs, maid and piece worker. At initial, she was doing office work for work relief program, 3 months - OVR schooling - poor attendance, did not finish; final - hairdresser.
- Final Staff evaluation-Because of overweight and personal problems i.e. depression, anxiety, financial problems, permanent employment may not be achieved. CHRP being rejected by this client was not very effective in promoting employability.

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- Female, age 22, head of household, 3 children - ages 5, 3, 1 (supported by own father); 9th grade education. Boyfriend and his 10 year old child live in household.
- Past Health History-spontaneous abortion.
- Presenting Health Problems-physical exam requested by referring agency.
- Chief Physical/Psychological findings-Anxiety depression. Beta score, 90, hypochondriasis initial 3, final - not available. (did not come in for final follow-up)
- Social Evaluation at initial-Somewhat anxious and tense about her personal life. Seemed unlikely, due to her positive attitude and motivation towards work, that she would let her problem interfere with employment.
- Social Evaluation at final-Personal life seemed to settle down and employment seems permanent.
- Current welfare duration-5 years.
- Welfare support at initial-$124.00, final $0.00 (case closed because of employment)
- Intervention-Job counseling response was excellent, attended 1 family planning counseling session. Psychological counseling was not done because of employment (7 contacts)
- Work History/Status-Employed 1 year, CETA job training in 1970, typing and filing. At initial, work relief DSS secretary, at 3 mos.-employed as clerk-secretary at DSS until final.
- Final Staff evaluation-Employment seems permanent but because of clients lack of participation with CHRP, it would be difficult to indicate. CHRP was moderately effective in promoting employability.

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- Female, age 25, head of household, no children; 11th grade education, High school equivalency achieved.
- Past Health History-premature at birth, anemia, constipation, severe menstrual cramps, hepatitis, syphilis.
- Presenting Health Problems-question of headlice.
- Chief physical/psychological findings-visual impairment, poor muscle tone, neurosis (behavorial disorder). Beta score 91, hypochondriasis initial 20, final 12.
- Social Evaluation at initial-Low self-esteem and defeatist attitude. Client was shy and withdrawn and persecutes herself by denying her intelligence and by invalidating her interests. Good motivation to work but admits to being laid off because she works at a very slow pace.
- Social Evaluation at final-More outgoing and secure. Very happy at present job but still slow and denies herself the opportunity to work in the field for which she is more qualified and interested.
- Current Welfare Duration - 33 months.
- Welfare Support at initial-$187.30, final $0.00 - case closed because of employment.
- Intervention-Excellent response to health education and exercise classes, minimal and moderate response to job and psychological counseling. (24 contacts)
- Work History/Status-Kitchenwork, child care, gardening. Last year of employment was 1971. Total time employed was 9 months during which she held 3 jobs. At initial, she was unemployed,at 3 months, she was babysitting part-time, at 6 months, she was in job counseling with EOC and CHRP and at final she was working as a full-time CETA nursery-school aide.
- Final Staff evaluation-Client says her work is tiring but enjoys it very much. Motivation for keeping her full-time employment is excellent. Prospect for employment in competitive market is guarded due to her excessive shyness and slow pace. CHRP was moderately effective in promoting employability.

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- Male, age 48, head of household, 1 child, age 6, custody granted in 9/77; 7th grade education.
- Past Health History-bad back.
- Presenting Health Problem-back problem.
- Chief Physical/Psychological findings-Chronic bronchitis, emphysema, history of slipped disc. Beta 97, hypochondriasis initial 7, final 5.
- Social Evaluation at initial-Client's primary concerns were to regain custody of his daughter, to get a valid medical evaluation of his back problem and to find full-time employment. Very motivated to improve health, living conditions and employment.
- Social Evaluation at final-Found better living conditions, employment, received custody of daughter and day care.
- Current Welfare duration-3 years.
- Welfare Support at initial-$108.00, final $172.00 increase due to custody of daughter.
- Intervention-Client's response to health education, back evaluation and treatment, and job counseling was cooperative. (18 contacts)

- Work History/Status-He held 3 different jobs in 18 years of employment. One job was held for 18 years. He worked as a short order cook, maintenance man, and a driver. Last year of employment 1974. At initial, he was unemployed on work relief until final evaluation at which time he became full-time driver for DSS-CETA at $2.65/hr.
- Final Staff evaluation-Because of back problem, his employment as a driver is very satisfactory. He finds it to be very rewarding and has plenty of time to spend with his daughter. CHRP was moderately effective in promoting employability.

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- Male, age 26, head of household, no dependents; 10th grade education.
- Past Health History-Stomach problem, Hematemesis, drug abuse.
- Presenting health problem-stomach pain.
- Chief Physical/Psychological findings-Depression, alcoholism, undernutrition, gastritis, bronchitis. Beta score 102, hypochondriasis at initial 6, final not done because client was unavailable.
- Social Evaluation at initial-He was very anxious and depressed. His life was still unsettled because he was on parole. He was struggling with his freedom and sense of personal responsibility. He also faces flashbacks from using drugs. He seemed pulled between the life of the streets and getting a job, settling down.
- Social Evaluation at final-Alcohol/drug rehab counseling helped him deal with the tremendous amount of stress, he had to deal with re-parole, legal aid, employment and personal problems.
- Current Welfare Duration-6 months.
- Welfare Support at initial-$155.40, final $0.00 because of full-time employment.
- Intervention-Excellent response to psychological, job and alcohol counseling. Alcohol counseling was done at CHRP and through a referring agency. Good response to dermatology treatment. Did not attend health education or diet counseling. (48 contacts).
- Work History/Status-He held 3 different machine maintenance jobs and a stock boy job from 1974-76. Total years of employment - 19 months. At initial, he was unemployed and from 3 months - 6 months, he was incarcerated. At present, he is employed as a CETA school grounds keeper full-time.
- Final Staff Evaluation-Excellent course of rehabilitation through client's acceptance of alcohol rehab counselor and CHRP program. Good prospect for continued employment. CHRP was very effective in promoting employability.

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- Female, age 22, head of household, 1 child, age 5; graduated 9th grade level from BOCES - Special Education Class.
- Past Health History-Stomach ache - "Gallstones", rash.
- Presenting Health Problems-obesity.
- Chief Physical/Psychological findings-Mild mental retardation, gross obesity, mild hypertension, urticaria, periodontal disease, emotional immaturity, Beta score - 73, hypochondriasis initial 10, final 10.

- Social Evaluation at Initial-Overweight. Wanted help and support with personal and health problems. Had inferior intelligence, is emotionally unstable, yet motivated and eager to receive help. Problems with boyfriend.
- Social Evaluation at final-Still has some social problems at final plus lacking in motivation to work. Was employed but could not take the pressure of her schedule and her boyfriend's problems with the police. Very immature, not work oriented, always cancelled appointments with CHRP and others.
- Current Welfare Duration-2 years.
- Welfare Support at initial-$290.00, final $265.00 - decreased after she quit her job.
- Intervention-At first there was a good response to weight reduction, health education, and job counseling . No response to dental evaluation and treatment or psychological counseling . (30 contacts)
- Work History/Status-She has no job skills and had never been employed until 6 months after initial contact. She had been employed 4 months as a maid and at present, she is unemployed.
- Final Staff evaluation-Needs support and guidance from other support agencies in county. CHRP was moderately effective in promoting employability.

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- Female, age 27, head of household, 3 children - 6, 5, 4 - 2 are in foster homes and one lives with client's mother; Left school at age 18 on recommendation from school official.
- Past Health History-headaches, tubal ligation.
- Presenting Health Problem-illiteracy - Physical exam requested by referring agency.
- Chief Physical/Psychological findings-Mental retardation, iron deficiency anemia, emotional immaturity, diverticulum esophagus, systolic murmur, reduced vital capacity. Beta score 60, hypochondriasis initial 7, final 16.
- Social Evaluation at initial-Client was emotionally and intellectually immature. Motivated by the drive to get custody of children, she is being very willing and cooperative. Felt if she could get a job, she could provide for her children.
- Social Evaluation at final-Client still too immature to cope with children. Always gave up quickly when asked to do something or questions about employment.
- Current Welfare Duration-6 years.
- Welfare Support at initial-$220.00, final $224.00.
- Intervention-Response to diet counseling and treatment of anemia was excellent although client was reluctant; cooperative during job counseling . (67 contacts)
- Work History/Status-For 1 year, she was employed as a dishwasher in 1969. At initial through final, she remained unemployed.
- Final Staff Evaluation-Appropriate for OVR - sheltered workshop job training. CHRP was not effective in promoting employability.

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- Female, age 22, lives with boyfriend, who is head of household and his three children - 10, 8, 5; High school graduate.
- Past Health History-diarrhea, vertigo, vaginal infections.
- Presenting Health Problem-recurrent diarrhea.
- Chief Physical/Psychological findings-Anxiety depression, varicose veins, poor muscle tone, cervical dysplasia, history of recurrent diarrhea. Beta score 105, hypochondriasis initial 11, final - did not return for final follow-up.
- Social Evaluation at initial-Client seemed intelligent and had a fairly objective outlook on her life situation although she was tense and troubled at that time. She stated her main problem was her relationship with her alcoholic boyfriend.
- Social Evaluation at final-Because of her motivation to find a job, she was getting out of the house and doing things for herself. Seemed less tense and nervous. Separated from boyfriend after she found a job.
- Current Welfare Duration-2 1/2 years.
- Welfare Support at initial-$62.00, final $0.00 - client was employed.
- Intervention-Cooperative towards job counseling, little response to psychological counseling and health education (8 contacts)
- Work History/Status-She had been employed in 1974 and 1976 as a maid, salesgirl, laborer, waitress and cook and daycare mother. She held 5 different jobs in 1 1/2 years. From initial to 6 months, she was unemployed. At 6 months until present she was employed full time as a nurse's aide at $2.50/hr.
- Final Staff Evaluation-Although self-referred, client chose to act independently of CHRP. CHRP was not effective in promoting employment.

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- Female, age 35, married, 3 children, ages 11, 9, 5; 9th grade education.
- Past Health History-Broken left wrist, hypertension, dental decay, tubal ligation.
- Presenting Health Problems-obesity and hypertension.
- Chief Physical/Psychological findings-gross obesity, mild hypertension, periodontal disease, dental caries, neurosis, anxiety. Beta score 115, hypochondriasis initial 4, final not done because of employment, client was unavailable.
- Social Evaluation at initial-Client very sensitive and emotional (cried during interviews). Her dental problems were a great source of embarrassment, very self conscious, low self-esteem and felt incapable of doing much outside the home.
- Social Evaluation at final-After dental extractions, client felt better about herself and wanted to join CHRP weight reduction program but found a job first.
- Current welfare duration-1 year.
- Welfare Support at Initial-$201.00.At final, $176.10 - lowered because of employment.
- Intervention-Excellent response to dental treatment plans. Weight reduction, individual and group counseling not attended because after she was fitted with dentures, she found immediate employment. (4 contacts)
- Work History/Status-She held 3 different jobs from 1964 - 1968. She had been employed for 3 1/2 years in factory, production and poultry farm work. At initial, she was unemployed, 3 months until present - employed as a waitress.
- Final Staff Evaluation-Good self-motivation after dental care was completed. CHRP was moderately effective in promoting employability.

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- Male, age 37, head of household, married; 3rd grade education.
- Past Health History-Inguinal hernia - right side, concussion head injury, cold exposure, learning disability, mental health problems, nervousness, blackouts, alcoholism, cirrhosis of the liver, renal calculus, fractured right ankle.
- Presenting Health Problems-alcohol abuse.
- Chief Physical/Psychological findings-Alcoholism, Laennec's cirrhosis, onychophagy, periodontal disease, dental caries, sick role behavior. Beta score - 100, hypochondriasis initial 20, final 12.
- Social Evaluation at initial-Easily upset, altered sleeping, unable to cope with problems at home without drinking. Wife extremely possessive. Client in 4 foster homes from age 10-12, in state institution for retarded/ emotionally disturbed persons from age 12-21. When discharged, unable to keep jobs since then. Impaired verbal/education abilities. Very poor hygiene,unkempt appearance, lacked confidence, poor self image.
- Social Evaluation at final- Quite responsive initially to counseling and supportive services. Wife was threatened by his reaching out for help and exerted whatever pressures she could to prevent outside interference in their lives. Little personal improvement was seen.
- Current Welfare Duration - 2 years.
- Welfare Support at initial-$201.60. final - $224.00. Client has since moved out of state.
- Intervention-7 months of alcohol counseling . Response and attendance sporadic but receptive. Referred to a alcohol rehab program. Referred to a detox unit but after 3 days, he signed himself out. Cooperative and then rejected psychological counseling . Job, support, and health education attendance sporadic. Good response to dental treatment for 6 months. (133 contacts)
- Work History/Status-Employed from 1961-1976 in 68 different jobs throughout the United States. At initial through 6 months, remained unemployed, taking some volunteer jobs. At final follow-up, he was selling vitamins part-time. At present, he lives in another state - unemployed.
- Final Staff evaluation-After dropping out of the alcohol counseling program, regression was seen. Given his social problems and recurrent alcoholism, number of jobs held, and long history of agency help, CHRP sees little hope for employability on continuing basis. CHRP worked hard trying to rehabilitate him and was not effective in promoting employability.

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- Male, age 32, head of household, no children; high school graduate.
- Past Health History-TB right wrist, withdrawal-emotional.
- Presenting Health Problem-depression.
- Chief Physical/Psychological findings-Episodic-alcoholism, depression, periodontal disease, dental caries, chronic bronchitis, history of mental disease. Beta 116, hypochondriasis initial 4, final - unknown rejected CHRP.
- Social Evaluation at initial-Anxious and depressed. Has altered patterns of eating and sleeping, fidgety, chain smoker. Mother in the hospital very ill. Emotional problems he feels keeps him from finding and keeping a job. Has a 16 year old brother he has to take care of and this also puts a strain on his emotional problems.

- Social Evaluation at final-During the course of his involvement with CHRP, there were several incidents of erratic and violent behavior usually when he was intoxicated. He was placed on one job and left after two hours. His mother died + he now lives with brother and boarder. Does not seem interested in working or making progress on his personal problems.
- Current welfare duration-1 year.
- Welfare Support at Initial-$121.30, final $185.30.
- Intervention-He rejected psychological, health, and alcohol counseling at CHRP. Attended a few job counseling sessions, did not go for dental treatments and only attended 1 meeting at a alcohol rehabilitation program (22 contacts).
- Work History/Status-He was last employed in 1976. Before that he held 4 different jobs in 6 years. He worked as a store manager in the Army, salesman, bartender and factory worker. At initial, he was unemployed, at 3 months, he was in jail, unemployed during 6 months' follow-up and on work relief at the final.
- Final Staff Evaluation-This client has violent and erratic behavior due to drugs and alcoholism. There is no apparent motivation for employment or rehabilitation at this time. CHRP was not effective in promoting employability.

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- Male, age 30, head of household, no children; high school graduate, 2 years of extra schooling.
- Past Health History-Myopia, back problem, hemorrhoids, infectious hepatitis.
- Presenting Health Problem-back problem.
- Chief Physical/Psychological findings-Sick role behavior, myopia, anxiety neurosis, back problem, external hemorrhoid. Beta 120, hypochondriasis initial 17, final 5.
- Social Evaluation at initial-Intelligent, creative, energetic and had very positive personal resources. Had personal-emotional problems re: separation from wife and daughter which were confusing him. Excellent motivation to obtain barber credentials and open his own stylist shop.
- Social Evaluation at final-Had acquired financing and apartment to open his own barbershop after OVR training in N.Y.C. Emotional problems seemed to resolve after his motivation to open and start his new business.
- Current welfare duration-1 year
- Welfare Support at initial - $194.00, final $276.00. Increased support in July - OVR incentive, and rent increase.
- Intervention-Good response to back evaluation and treatment, eye evaluation, psychological counseling. Excellent response to job counseling. (13 contacts)
- Work History/Status-From 1965-1975, he was employed at 12 various jobs - bankteller, clerk, assistant manager of fast food chain, computer programmer, laborer in factory. At initial, he was unemployed, 3 months - OVR hairdressing school through 6 months. At final, self-employed hairdresser: $160.00/week.
- Final Staff evaluation-Because of his goal to become a hairdresser, he had enough motivation to follow through and open his own shop. We feel he will be highly successful because he has several clients all ready. CHRP was very effective in promoting employability.

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- Female, age 27, head of household, 2 children - ages 7, 6; 10th grade education.
- Past Health History-Appendicitis, appendectomy, tonsillitis, tonsillectomy, vaginal cysts, auto accident -- fracture of left wrist, lacerations both legs.
- Presenting Health Problem- obesity.
- Chief Physical/Psychological findings-Obesity, folliculitis, poor hygiene, poor muscle tone. Beta score 102, hypochondriasis initial 6, final, 1.
- Social Evaluation at initial-Lacked direction and career guidance. Motivation was toward employment.
- Social Evaluation at final-Found employment at 3-month follow-up. She did not like her job but was committed to working. She also found day care for her children and after the final evaluation, she had gotten married, still employed and enjoys her work and her family.
- Current Welfare duration-8 years.
- Welfare Support at initial-$359.00, final $167.00. (employed)
- Intervention-She attended job, health education, and weight reduction counseling with good response before employment. (10 contacts)
- Work History/Status-In 1970, she worked 1 month doing piece work on a drill press and in 1976, she was a teacher's aide for 6 months. At initial, she was unemployed and at 3 months through final, she was employed full-time in a laundry at $2.65/hour.
- Final Staff Evaluation-Client seems to be working at appropriate level and is committed to her work. CHRP was very effective in promoting employability.

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- Male, age 24, head of household, no children; high school graduate.
- Past Health History-Fractured 4th finger left hand, alcoholism.
- Presenting Health Problem-Alcoholism
- Chief Physical/Psychological findings-Chronic alcoholism, neurosis. Beta score 125, hypochondriasis initial 12, final - not done because of school schedule.
- Social Evaluation at initial-recent detoxification and sobriety - long history of alcoholism, released from the Air Force due to his alcoholism. Found it hard to adjust to everyday life after he stopped drinking. Wanted to build up self-confidence. He was self-motivated but lacked self-assurance and self-esteem.
- Social Evaluation at final-He was doing quite well and feeling better about himself. He did start drinking again after his first job ended but stopped shortly after starting. He started school at a local college and was able to deal with problems and not drink although he is prone to episodic drinking.
- Current Welfare Duration-1 year.
- Welfare Support at initial-$94.00, final $0.00, DSS case closed.
- Intervention-He was receptive to support for alcohol counseling, good response to psychological counseling, excellent response to job counseling and fair response to health education (25 contacts).
- Work History/Status-Employment started in 1969 and ended in 1976. He had a total of 6 jobs and 4 1/2 years of employment as laborer, electronic's mechanic, bartender, assembly work, roofing and U.S. Air Force. At initial, he was unemployed, 3 months CETA Foreman grounds work $5.65/hr., 6 months, community college (VA) through final.
- Final Staff Evaluation-He has defined his career goal (mechanical technology) and has started schooling to achieve this goal. CHRP was moderately effective in promoting employability.

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- Male, 19, head of household, 1 child - age 1; 11th grade education.
- Past Health History-Tonsillitis, tonsillectomy, viral infection, drug abuse, drug overdosage, peptic ulcer, fractured ribs left side.
- Presenting Health Problems-Multiple health problems.
- Chief Physical/Psychological findings-Moderate obesity, gastritis, periodontal disease, emotional immaturity. Beta score 111, hypochondriasis initial 12, final 8.
- Social evaluation at initial-Emotional immaturity, lacked social control, prone to temper outbursts and anger in social situations. Unfulfilled ambitions, lacked job experience, threatened by work. Personal problems with wife, imbalance in interests, didn't get along with others, wife interested in others.
- Social evaluation at final-Initiated his own counseling sessions on an "as needed basis". His wife did leave him and son and he was faced with the responsibility of a single parent. Employed once and gave up. Arrested for stolen property.
- Current Welfare Duration - 22 months.
- Welfare support at initial-$354.00, final $274.00 (wife moved out).
- Intervention-Dental, weight and diet counseling was rejected by client, psychological counseling requested by client with some improvement, rejected job counseling and school plans. Cooperative towards support. (28 contacts)
- Work History/Status-Before coming to CHRP, he held a "go for" job delivering Pizzas for 1 month. At initial, he was unemployed, 3 months CHRP arranged for high school equivalency degree studies, he rejected this, at 6 months he was employed as a grounds keeper $2.35/hr. rejected after 2 weeks. At final, he was unemployed.
- Final Staff Evaluation-Referred to family and children's service for on-going counseling. Is assuming more responsibility, may have sales job soon. Motivated to establish his own independence. CHRP was moderately affective in promoting employability.

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- Female, age 27, head of household, 1 child - age 4; 10th grade education.
- Past Health History-Tonsillitis, Tonsillectomy, constipation, recurrent cystitis.
- Presenting Health Problem-overweight
- Chief Physical/Psychological findings-moderate obesity, anxiety depression, poor hygiene. Beta score 98, hypochondriasis score initial 5, final not done, felt she did not need CHRP.
- Social Evaluation at initial-Positive qualities and apparently quite motivated. Interested in counseling re: marital difficulties. Seemed depressed and anxious and yet ambitious enough to seek help to overcome her problems.
- Social Evaluation at final-Reunited with her husband and had a baby.
- Current Welfare Duration-3 months.
- Welfare Support at initial-$0.00, final $0.00 - unemployment insurance.
- Intervention- Client rejected weight reduction, psychological counseling and health education.
- Work History/Status-From 1969-1977, she was employed at 4 different jobs, assembly line, domestic, stock girl and factory, total years of employment 5. At initial through final evaluation, she remained unemployed.
- Final Staff Evaluation-Motivated to work, wanted secretarial skills but family matters had priority. CHRP was not effective in promoting employability.

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- Female, age 30, head of household, 3 children - ages 14, 12, 11; 9th grade education.
- Past Health History-Appendicitis, appendectomy, menorrhagia, dust inhalation, neuritis left arm.
- Presenting Health Problems-Overweight.
- Chief Physical/Psychological findings-Gross obesity, brachial neuritis, impaired vital capacity, impaired exercise tolerance, dental caries, partially edentulous. Beta score 119, hypochondriasis initial 10, final 5.
- Social Evaluation at initial-Recently separated from husband and trying to establish independence through education but motivation to try. Tense and nervous about the future.
- Social Evaluation at final-Very involved in weight reduction at home, school and her children. Wanted to get driver's license and did. Received high school equivalency and accepted into nursing program.
- Current Welfare Duration-10 months.
- Welfare Support at initial-$354.00, final $360.00. Welfare recovery money stopped and gave her an increase.
- Intervention-Transportation problems kept her from in-house weight reduction but did lose 30 lbs. with information received from CHRP. Very cooperative during dental evaluation and treatment. Excellent response to job and support counseling. Client referred for legal aid at the client's request. (36 contacts).
- Work History/Status-She was employed 1 1/2 years as a janitor in 1972 and at initial she was unemployed through 6 months at which time she attended a local community college through CETA and obtained her high school equivalency. At final, she was accepted into the college nursing program.
- Final Staff Evaluation-Exceptional motivation to acquire job skills and further her education. Prognosis excellent regarding all her goals.

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- Female, age 25, head of household, 3 children - ages 8, 3, 2; 11th grade education.
- Past Health History-Fractured left clavicle, lacerations right knee, facial injury, nervous breakdown, drug abuse.
- Presenting Health Problem-Neurosis, alcohol abuse, obesity.
- Chief physical/psychological findings-Episodic alcoholism, obesity, conjunctival hemorrhage. Beta score 103, hypochondriasis initial 6, final - not available, moved out of county.
- Social Evaluation at initial-Extensive history of drug-alcohol abuse, a long police record and two psychiatric in-patient hospitalizations. Admitted to not having control of herself and to feelings of unacceptance and inadequacy. Past history also included anti-social aggressive personality disorder and physical abuse by her ex-boyfriend.
- Social Evaluation at final-Client had moved out of the county before final evaluation was done.
- Current Welfare Duration-3 years.
- Welfare Support at Initial-$238.00, final $0.00 (moved out of county)
- Intervention-Psychological, job counseling and weight reduction rejected by client (2 contacts).
- Work History/Status-She was employed for 6 years in 5 different jobs. Topless dancer, mail clerk, office clerk, factory work. Her last year of employment was 1976. At initial, she was unemployed but registered with community jobs program. At 3 months, she had moved out of the county.
- Final staff evaluation-She had manpower training in the past and wants secretarial training but needs to overcome her lifestyle before there is potential for success. CHRP was not effective in promoting employability.

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- Female, age 30, head of household, 1 child - age 4, 8th grade education.
- Past Health History-blood disorder requiring 16 transfusions, asthma, pulmonary tuberculosis, anemia, back problem, acute appendicitis.
- Presenting Health Problem-emotional.
- Chief Physical/Psychological findings-Emotional immaturity, undernutrition, alcoholism, periodontal disease, poor hygiene, poor muscle tone. Beta score 102, hypochondriasis initial 10, final - moved out of county.
- Social Evaluation at initial-This client was basically suspicious, nervous and had frequent nightmares which she has had since childhood. Had conflicts with an alcoholic boyfriend which caused the removal of her 3 children from her home, and this made her start drinking and she left her boyfriend.
- Social Evaluation at final-Since the boyfriend has left, she moved, stopped drinking, has custody of 1 child, and is seemingly coping with difficulties, improved mentally and physically.
- Current Welfare duration-4 years.
- Welfare Support at initial-$341.50, final $0.00 - moved out of county.
- Intervention-Nutrition, health education, alcohol and psychological counseling was not done because she moved before intervention could begin (0 contacts).
- Work History/Status-In 965, she held 3 waitress jobs and 1 job for 1 week as a nurse's aide. She was employed less than 1 year. Unemployed at initial and then moved out of the county.
- Final Staff Evaluation-Apparently rejoined estranged husband in Syracuse. Poor prognosis for employability without better health and ability to adequately handle personal problems. CHRP was not effective in promoting employability or rehabilitation because she moved out of the county.

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- Male, age 35, head of household, no children, high school graduate.
- Past Health History-pneumonia, tonsillitis, tonsillectomy, nasal allergies, measles, anti-social behavior, contusions of chest, sprained ankle, alcoholism, amblyopia, sinusitis, larygeal polyps.
- Presenting Health Problem-Overweight
- Chief Physical/Psychological findings-alcoholism, alcoholic hepatitis, sick role behavior, obesity, visual defect, anxiety depression. Beta score 112, hypochondriasis initial 13, final 4.
- Social Evaluation at initial-Inadequate social relations with others, internalized anger resulting in withdrawal. Lacking in self-esteem, feelings of inferiority.
- Social Evaluation at final-Psychological and emotional improvements seen after counseling re: attempted suicide. Became more aware of himself, more direct with others, assertive in a constructive way and established friendships. Viewed himself more positively. Motivated toward employment.
- Current Welfare duration-15 months.
- Welfare support at initial-$179.00, final $224.00 - increased because of OVR incentive and rent increase.
- Intervention-Good response to alcohol, diet, job, support, psychological counseling, weight reduction and an opthalmological evaluation. Responded well to CHRP, alcohol rehab program, NYSES combined staff input (30 contacts).
- Work History/Status-He had been employed a total of 9 years as a laborer, factory and knitting mill. At initial, he was unemployed, attended refrigeration school through OVR at 3 months for 3 weeks, unemployed at final.
- Final Staff Evaluation-Inter-agency support affected definite improvements in his present and future outlook. CHRP feels support should continue after client obtains job. CHRP was very effective in promoting employability.

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- Female, age 47, head of household, 3 children - ages 17, 8 (set of twins); high school graduate.
- Past Health History-Dental problems, fractured right lower leg, back problem, benign uterine tumor, fractured left scapula, injury to right eye (multiple injuries resulting from car accident).
- Presenting Health Problem-Anxiety.
- Chief Physical/Psychological findings-Periodontal disease, late effects of injury to right ankle, lordosis, anxiety depression, refractive error. Beta score - not done - seems average, hypochondriasis initial 18, final 10.
- Social Evaluation at initial-Very nervous and tears during interview but honest and open to accepting help, willing and motivated to work. Facing trauma of recent separation from her husband and two sons that were taken by him and the loss of her home.
- Social Evaluation at final-Has regained custody of sons but oldest daughter causes anxiety within her because daughter is pregnant. Her apartment is very crowded now and may have to find a new apartment. Wants to work but personal family problems prevent her from leaving the home.
- Current Welfare duration-7 months.
- Welfare Support at initial-$449.00, final $620.00 - increase in family size.
- Intervention-Excellent response to evaluation of ankle, dental evaluation, visual exam, psychological, job and support counseling. (20 contacts)
- Work History/Status-Year she was last employed was 1960. She had worked as a maid, cashier and barmaid. She with her husband owned a bar and store. At initial through final, she was unemployed.
- Final Staff Evaluation-Unemployable pending solution of personal/family problems. Good candidate for companion work and is motivated towards this type of employment. CHRP was moderately effective in promoting employability.

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- Female, age 25, head of household, 1 child in foster care - age 5; 9th grade education.
- Past Health History-Pain in chest.
- Presenting health problem-overweight.
- Chief Physical/Psychological findings-Alcoholism, obesity, rosacea, scabies, poor hygiene, acute bronchitis, periodontal disease, borderline mental retardation. Beta score 98, hypochondriasis initial 9, final 5.
- Social Evaluation at initial-Child in foster home, motivated for job, and self-improvement in order to have child returned. Lonely, isolated and sad. Alone most of the time, very nervous, no social life. Physically unsightly, unkempt, and dirty, emotionally distraught, insecure and withdrawn.
- Social Evaluation at final-Child still in foster care. Personal hygiene improved. Moved into larger apartment, making new and helpful friends. More open about her feelings and motivated to find the right job.
- Current Welfare Duration-5 years.
- Welfare Support at initial-$73.00, final $209.00. - rent increase.
- Intervention-Excellent response to alcohol treatment/counseling, weight reduction, diet counseling, health education/referrals, and job counseling. (207 contacts)
- Work History/Status-Before coming to CHRP, she was employed 3 months as a maid 15 hr./wk, $2.35/hr. 3 months, she was unemployed, at 6 months, volunteer aide in a nursery school.
- Final Staff evaluation-Volunteer job is upgrading, parenting skills necessary for return of son. Motivated to work. CHRP was very effective in promoting employability.

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- Female, age 19, head of household, 1 child - age 1, now living with father; 9th grade education.
- Past Health History-Synovitis right knee, chronic bronchitis, tonsillitis, tonsillectomy, varicose veins.
- Presenting Health Problem-Overweight.
- Chief Physical/Psychological findings-Chronic bronchitis, cardiac arythmia, mild obesity, varicose veins, poor hygiene, refractive error, emotional immaturity. Beta score 115, hypochondriasis initial 3, final 5.
- Social Evaluation at initial-Erractic eating and sleeping patterns because of anxiety, problem with husband, she is in process of separation with unresolved feelings of leaving husband and baby and establishing her own independence. Highly motivated to find employment.
- Social Evaluation at final-Emotionally immature, prone to outbursts of anger on occasion and still has difficulty expressing feelings in front of others. Felt leaving husband and child will help motivate her towards self-improvement and open to receiving help and support. Now pregnant by new boyfriend.
- Current Welfare Duration-1 1/2 years.
- Welfare Support-after separation from husband - $77.40, final $0.00. - DSS case closed.
- Intervention-Client rejected health education, evaluation and treatment of bronchitis, cardiac evaluation, and weight reduction. Good response to psychological counseling (seeking independence) and moderate response to job counseling. (4 contacts)
- Work History/Status-She was employed for 6 months and held 4 different jobs, public relations secretary, piece worker, secretary, factory. At initial she was unemployed, at 3 months she was employed full-time by CETA, office helper at $100.00/wk. at final, she was unemployed, lost job due to absenteeism.
- Final Staff Evaluation-Needs on-going counseling, but not interested. Not a good job risk at present. CHRP was moderately effective in promoting employability.

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Syracuse

- Female, age 23, head of household, 4 children - ages 5, 4, 3, 2. Male friend lived in, worked, also on welfare. Client left school (8th grade) age 16.
- Past Health History-lifelong anemia
- Presenting Health Problem-Physical exam requested by referring agency.
- Chief Physical/Psychological findings-fatigueability, decreased exercise tolerance. Beta score 70. Hypochondriasis score at initial 6, at final 2.
- Social Evaluation at Initial-Perceived herself to be in good health. Coped normally with problems. Her purpose in coming to CHRP was to seek help with employment.
- Social Evaluation at Final-none
- Current Welfare Duration-5 years
- Welfare Support- at initial - $190.00, at final - $267.00.
- Intervention-Exercise program to increase stamina and vital capacity - 2 months. Vital capacity improved slightly. (22 contacts)
- Work History/Status-School aide, domestic, assembly work. She had worked 2 years, 3 months had 3 jobs. Last worked in 1970. Referred to CHRP by SETA. She was in job training 1/2 day and school 1/2 day at 3 months. Self-placed in factory assembly work $3.20/hr. (raised from $2.30/hr.) 7 months after entry.
- Final Staff evaluation-Client had few health problems. She responded well to CHRP exercise program. Likes her work and has gained needed weight (12 lbs.).

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- Female, age 52, head of household, mother of 3 children - one age 8 at home. Client had male friend living with her - receives social security; 8th grade education leaving school at 15.
- Past Health History-She detailed a life of health problems; repeated bouts of pneumonia, scarlet fever, tonsillitis and bowel trouble as a child, stomach pains, kidney problem, enlarged heart, conjunctivitis, arthritis, sleep problems, cholycystitis, caesarian sections and varicose veins as an adult.
- Presenting Health Problem-Referred for evaluation of stomach hernia, arthritis of knees and emphysema.
- Chief Physical/Psychological findings-Ill-fitting dentures, not worn. Right flank myalgia, cardiomegaly, obesity, hiatal hernia, seborrheic dermatitis, arthritis, knees, spine, congenital urinary problem (double collecting system), anxiety. Beta score 99, hypochondriasis at initial 18, at final 15.
- Social Evaluation at Initial-Client came seeking help with health problems impeding employment. Frustrated, she was converting problems into somatic complaints. She also had problems with an older daughter.
- Social Evaluation at Final-She had developed insights and better handling of social problems. Mental status improved.
- Current Welfare Duration-9 years.
- Welfare Support-At initial - $291.00, at final - $263.00 (changed residence).
- Intervention-Individual and group counseling, an exercise program, and weight reduction were all well received by client. She was fitted for new dentures but would not wear the lowers. (30 contacts)
- Work History/Status-Assembly work in 1967. She held the job 12 months.
- Final Staff Evaluation-Work could be the solution to many problems for her, but her age, minimal work history and health mitigate against employment, even in her improved physical-emotional state.

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- Female, age 23, not head of household, child - age 1, lives with her boyfriend who works; high school graduate.
- Past Health History-She related "a touch of polio" as a child, also appendicitis, tonsillectomy, allergies. As an adult, she said she had had a back problem, constipation, chest pains, miscarriage and pneumonia.
- Presenting Health Problem-Back problem, skin problem, constipation.
- Chief Physical/Psychological findings-Dermatitis, hands, back problem, post-polio, chest pain, constipation, anxiety syndrome and dorsal scoliosis. Beta score was 114, hypochondriasis at initial 9, at final 4.
- Social Evaluation at Initial-Client came seeking job training and placement. Although she left her job due to back trouble, she was optimistic about work. She expressed a phobia about public transportation, was socially withdrawn and dependent on boyfriend.
- Social Evaluation at Final-Rejected counseling after 2 times.
- Current Welfare Duration-2 years.
- Welfare Support-At initial - $132.59, at final (3 months) $132.59.
- Intervention-Already in doctor's care for back. Followed doctor's orders for dermatology problem. Did not perceive CHRP as prerequisite to employment.
- Work History/Status-factory assembly, 9 months, bankteller 9 months, Last worked in 1974. While with CHRP, she was ambivalent about SETA Job Training.
- Final Staff Evaluation-She needs job skills but may not seek them. Motivated to work. She moved to Florida 4 months after evaluation to seek employment there.

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- Female, age 36, head of household, 2 children - ages 14, 12; 8th grade education, left school at 16 to work.
- Past Health History-Hospitalized for nervous breakdown 1960-62. Gall bladder obstruction, asthma 1975-76, treated medically. She had received treatment for dizzy spells and plantar's warts and used diet pills for weight loss. Tubal ligation 1975.
- Presenting Health Problems-Plantar wart, gall bladder disease, family problems.
- Chief Physical/Psychological findings-Hypertension, obesity, non-functioning gall bladder, plantar callous, anxiety state, asthma. Beta 97, hypochondriasis at initial 8, final 8.
- Social Evaluation at Initial-Insecurity and a sense of powerlessness in dealing with problems. Emotionally unstable.
- Social Evaluation at final-Not reported. Client refused counseling.
- Current Welfare Duration-9 years.
- Welfare Support-at initial $292.00, at final $292.00.
- Intervention-Attended 4 sessions of weight reduction diet and exercise, then cancelled several sessions. Refused gall bladder evaluation, denied anxiety. Foot problem improved with outside care. (17 contacts)
- Work History/Status-3 jobs as waitress, housekeeper, factory worker. Employed 3 years, last worked 1959.
- Final Staff Evaluation-She is capable of doing a sitting job and indicated an interest in being a telephone operator. Level of motivation is low. At final, she was applying for licensing as day care mother. CHRP unable to effectuate much change to promote employability.

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- Male, age 50, head of household, infant son and the baby's mother who are also on welfare live with him. Left school at 16 to go to work, having completed 6th grade.
- Past Health History-Slipped disk and back pain for 22 years; numbness of hands with certain work for 9 years.
- Presenting Health Problem-chronic back sprain, neuritis in fingers, may need glasses.
- Chief Physical/Psychological findings-Degenerative arthritis, spine, poor hygiene, dental accretions, poor near vision, obesity. Beta score 93, hypochondriasis at initial 13, at final 17.
- Social Evaluation at Initial-Client sought help with back and vision to increase his employability. Also needed help with hygiene and job seeking skills.
- Social Evaluation at Final-Appeared cleaner, but odor was offensive.
- Current Welfare Duration-2 years, 4 months.
- Welfare Support-at initial - $213.32, at final $233.33.
- Intervention-Excellent response. Health education, weight reduction, dental care and back exercises produced better hygiene, 7 lb. weight loss, dental cleaning and restorations, also reduced back pain. Lab studies revealed gonorrhea, for which he was treated. Also treated for a new shoulder bursitis. Job counseling showed no deterrents to employment other than physical limitations (17 contacts).
- Work History/Status-Janitorial and factory work. He worked 26 years in 6 jobs, was last employed in 1975. Registered with WIN 11/76, placed in job search 3/77, unemployed as of 2/16/78.
- Final Staff Evaluation-Client is capable of working full time. Is highly motivated. Job training should be made available to him. CHRP contact promoted a moderate improvement in his employability.

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- Female, age 37, head of household, 2 children - ages 18, 13; 11th grade education.
- Past Health History-Appendectomy as a child, depression, onset age 6, to which she ascribed drug and alcohol abuse with hospitalization and detoxification most recently in the fall of 1975. She had tubal ligation and vein stripping in 1972. Cervical cancer was diagnosed in 1975 and total hysterectomy scheduled for 1 1/2 months after CHRP entry. She was treated in 1972 for pain in left shoulder and for aching knees. She also indicated a long history of backaches.
- Presenting Health Problem-Arthritis and bone problems in knee and arm.
- Chief Physical/Psychological Findings- Chondromalacia, patella, subdeltoid bursitis, varicose veins. Schizoid behavior. Beta 105, hypochondriasis at initial 19, at final 11.
- Social Evaluation at initial-attractive appearance, anxious about children and pending operation. Fear and hatred of men, delusions of persecution. Unfulfilled ambitions for self, inability to find a job.
- Social Evaluation at final-Stated she was not depressed post-operatively. Contact inadequate for further evaluation.
- Current Welfare Duration-1 year, 4 months.
- Welfare Support-$351.00 at initial, $71.12 at final.
- Intervention-She was counseling by the doctor once regarding pending operation, and twice for personal problems. Post-operatively, she rejected further help. (11 contacts)
- Work History/Status-Almost 11 years employment in 5 different jobs, working as nurse's aide, waitress, nutrition aide, gas station attendent. Last worked in 1974.
- Final Staff Evaluation-Client found a job prior to 6-month follow-up, but would not divulge details.

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- Female, age 32, head of household, mother of 3, oldest child - age 15, her boyfriend and his child - age 16 lived with her; dropped out of school after 8th grade at age 16.
- Past Health History-tonsillectomy - age 8, 3 caesarean sections, was counseling in 1963 for anxiety, and had a tubal ligation in 1975.
- Presenting Health Problem-Nerves - Rh factor in blood.
- Chief Physical/Psychological findings-carious teeth, anxiety, ceruman in ear canals, obesity. Beta score 75, hypochondriasis at initial 17, at 3-month follow-up - 9.
- Social evaluation at initial-A nervous depressed person with personal and social problems. Wanted to marry boyfriend. He and his son had drinking problems. Her daughter recently had a child given for adoption. Felt problems prevented seeking employment.
- Social evaluation at final-not done. Client rejected help.
- Current Welfare Duration-1 year.
- Welfare Support at initial-$236.66, at final - $0.00.
- Intervention-Appointments were made to irrigate ears, instigate weight reduction program, counsel, and for dental treatment. She cancelled most and did not show for the rest. (14 contacts were attempted)
- Work History/Status-She had held 3 jobs for 2 months each, working as waitress, dishwasher, factory worker. Last worked 1975.
- Final Staff Evaluation-Rejected any help, claiming she did not need it. She repeatedly stated she did not want employment. She moved out of town.

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- Female, age 30, head of household, 2 children - ages 12, 10; graduated from high school at age 17.
- Past Health History-tonsillitis as a child, toxemia of pregnancy and high blood pressure in 1963, a kidney infection with another pregnancy, therapy in 1966 for anxiety related to divorce, two abortions, back problem, onset 1973, tubal ligation in 1975 and surgery for dysfunctional uterine bleeding, 1975.
- Presenting Health Problems-nerves, back problem, high blood pressure.
- Chief Physical/Psychological findings-anxiety, degenerative arthritis, L4-5 disk Beta score 99, hypochondriasis score at initial - 20, at final - 14.
- Social Evaluation at initial-thin, attractive appearance. Believed her back and high blood pressure prevented employment. Anxiety regarding divorce, terminally ill father. She and children in family counseling
- Social Evaluation at final-Lacked self-confidence, low self-esteem. Increased job motivation - had interviewed for, but not gotten several jobs.
- Current welfare duration-3 1/2 years.
- Welfare Support at initial-$350.00, at final - $341.66.
- Intervention-She was receptive to rehabilitation, attended regularly for psychological counseling and back exercises. Had back x-rays, discontinued antidepressant medication prescribed by psychiatrist. (23 contacts)
- Work History/Status-Security guard for 7 months in 1975.
- Final Staff Evaluation -Still greatly lacking in confidence. CHRP of moderate help, but needs job counseling and skills training. Would also need child care.

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- Female, age 37, head of household, 2 children - ages 13, 10; graduated from high school at 18.
- Past Health History-Obesity for 13 years, treated by diet and thyroid. One abortion, vaginitis with odor 1975 to present.
- Presenting Health Problems-vaginal odor.
- Chief Physical/Psychological findings-vaginitis, obesity, hypertension, poor hygiene, hypothyroidism (treated), plosis, left upper eye lid, left 5th trigger finger. Beta score 102, hypochondriasis at initial 2, at final 4.
- Social Evaluation at Initial-Appropriate behavior, seemed clean but odor was detectable. She had been fired from SETA job 2 1/2 months previous due to odor.
- Social Evaluation at Final-Free from odor, job-ready.
- Current Welfare Duration - 12 years.
- Welfare support at initial-$145.16, at final $231.00.
- Intervention-Health education and treatment for vaginal odor included home visits. Diet counseling, weight reduction. Lost 17 lbs. in 6 months. She was cooperative throughout. (18 contacts)
- Work History/Status-Two SETA jobs as clerk-typist - 2 1/2 years.
- Final Staff Evaluation-CHRP helped with employability.

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- Female, age 37, head of household, 4 children - ages 16, 12, 11, 10; high school graduate.
- Past Health History-Dermatitis hands, weight loss, 3 years, irregular menses, earaches, nerves.
- Presenting Health Problems-contact dermatitis hands, psoriasis.
- Chief Physical/Psychological findings-Psoriasis scalp, underweight, varicose veins left leg, atopic dermatitis, hands, mild anemia, anxiety. Beta score 120, hypochondriasis at initial 9, at final 2.
- Social Evaluation at initial-Appropriate appearance, skin blemished. Hyperactive, nervous. Involved in community activities surrounding her children. Planned to do babysitting.
- Social Evaluation at final - none done.
- Current Welfare Duration - 10 years.
- Welfare Support at initial-$432.00, at final - $488.68.
- Intervention-Dermatologic evaluation and treatment. Birth control counseling, diet counseling, job counseling. Help buying stove, refrigerator to qualify her as day care mother. Her anxiety state improved, but other problems remained the same. (20 contacts)
- Work History/Status-She had worked as a machine operator in 7 factory jobs over a 5 1/2 year period. She was babysitting in her home while in CHRP and licensed as day care mother.
- Final Staff Evaluation-Intervention moderately effective.

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- Female, age 37, head of household, mother of 2. Ten-year old child and boyfriend who has applied for welfare lived with her; left school at 18, having finished 8th grade, so she could go to work.
- Past Health History-Rickets as an infant, toxemia in 1957, lymphadenitis, mennorhagia, caesarian section, and a tubal ligation.
- Presenting Health Problem-Numbness - hands and feet, aches in neck, shoulders and feet.
- Chief Physical/Psychological findings-Bursitis-shoulders, varicose veins, obesity, asthma, cystocele, functional heart murmur, irregular periods. Beta score 109, hypochondriasis at initial 12, no final done.
- Social Evaluation at initial-Problems with emotionally disturbed son, problems with boyfriend. Numerous health complaints, desired job in nursing or secretarial work.
- Social Evaluation at final-not done.
- Current Welfare Duration-6 months.
- Welfare Support at initial-$291.00, at final - $0.00.
- Intervention-Recommended were: diet counseling, exercises for neck and shoulder, elastic stockings, pap smear, x-ray for abdominal mass. Client attended one diet counseling session before having GYN surgery and requesting her case be handled by local family medicine clinic where she had been a patient. (5 contacts)
- Work History/Status-Five housekeeping jobs, for 3 1/2 years - she last worked in 1975.
- Final Staff evaluation-Needed opportunity for job training without which her employability is restricted.

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- Female, age 37, head of household, 1 child - age 6; 9th grade education, leaving school at 16 because her father would not buy her books.
- Past Health History-Whooping cough and tonsillectomy before age 6, chronic fatigue and nerves as school child and throughout life. She had had a hemorrhoidectomy (1964), flatulence and indigestion, hiatus hernia, recurrent ear infections, a hysterectomy for infected uterus and surgical correction of deviated nasal septum. She had recently had sinus x-rays to determine cause of headaches.
- Presenting Health Problems-nervous condition.
- Chief Physical/Psychological findings-anxiety, chronic otitis externa, surgical menopause, asymptomatic hiatus hernia, left maxillary sinusitis. Beta score 91, hypochondriasis at initial 17, at final 9.
- Social Evaluation at initial-Social isolation, paranoid about leaving home. Had left jobs because of nerves. Present living conditions are bad because of neighbor.
- Social Evaluation at final-Moved. Some improvement in that she had learned to trust the friendship of the CHRP staff and accepted volunteer work part-time.
- Current Welfare Duration-10 years.
- Welfare support at initial-$292.00, at final - $292.00.
- Intervention-Individual and group counseling, relaxation techniques, general support for problems. Developed dependency on staff, but always reciprocated a kindness. Job counseling led her to apply for intake at OCETA, but there has been no follow-up (24 contacts).
- Work History/Status-Employed for 6 years, 4 months as waitress, sales clerk, fitting room attendant, last worked in 1968.
- Final Staff Evaluation-Capable of working full time.

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- Female, age 48, head of household, 1 child - age 12; 9th grade education, left school at 16 to work.
- Past Health History-"Lifelong" bronchitis and nerves. Tuberculosis and appendectomy as child, bursitis, shoulder 1970 to present, arthritis, back, menorrhagia, seizures 25 years, heartburn, kidney infection, urinary incontinence, miscarriage, premature delivery, menopause, palpitations, contact dermatitis, pain right calf.
- Presenting Health Problems-Arthritis, back, chronic bronchitis, nerves.
- Chief Physical/Psychological findings-Back pain (L-S syndrome),chronic phlebitis - right calf, chronic bronchitis, contact dermatitis, anxiety, obesity, edentulous, hyperuricemia. Beta score - 111, hypochondriasis initial - 17, final - 13.
- Social Evaluation at initial-Appropriate appearance, ascribed obesity to past problems. Nervous and depressed. Requested physical and emotional rehab but not work.
- Social Evaluation at final-Behavior indicated no intent to change.
- Current Welfare Duration-13 years.
- Welfare Support at initial-$270.00, at final - $291.00 (change of residence).
- Intervention-Referred for dentures, evaluation of bronchitis, treatment of phlebitis, bursitis and back. In-house, psychological, diet and smoking counseling, weight reduction. Sporadic compliance, motivated only by welfare coercion. Little progress. (16 contacts)
- Work History/Status-3 jobs, 2 years employment. Worked as waitress, chambermaid, maintenance. Last job 1974.
- Final Staff Evaluation-Not motivated to change or to work.

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- Female, age 30, head of household, 3 children - ages 13, 9, 6; left school after 8th grade.
- Past Health History-Ectopic pregnancy, hysterectomy, salpingoophorectomy, surgical menopause, nervous breakdown for which she was hospitalized, and allergies.
- Presenting Health Problems-Effects of nervous breakdown.
- Chief Physical/Psychological findings-anxiety, underweight, viral syndrome. Beta 100, hypochondriasis at initial 6, at final 2.
- Social Evaluation at Initial-Very attractive appearance, introspective, untrusting. Social isolation. Motivated to work, to change.
- Social Evaluation at Final-Significant improvement socially and personally.
- Current Welfare Duration-10 1/2 years
- Welfare support at initial-$378.00, at final $255.00.
- Intervention-Psychological and job counseling - responsible attendance, serious involvement with progress. Diet counselling produced 14 lb. weight gain. (24 contacts)
- Work History/Status-Migrant worker, dishwasher, apprentice baker. 5 jobs in 2 years, last worked in 1966.
- Final Staff Evaluation-Very effective rehabilitation. High school equivalency in progress. Also clerical studies at community college. Prognosis for employment excellent.

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- Female, age 48, lived in son's house with 3 sons and daughters-in-law. Left school after 10th grade to work.
- Past Health History-Hepatitis 1954, stillbirth, premature delivery, slipped disk, nerves and conversion hysteria at menopause, tremor of head and kidney stones.
- Presenting Health Problems-nervousness.
- Chief Physical/Psychological findings-Tremor, head and upper body. Impaired breathing, anxiety, dental caries. Beta 84, hypochondriasis at initial 10, at final 17.
- Social Evaluation at Initial-Shabby unhealthy appearance. Bad teeth, nervous. Financial problems caused recent eviction and move to son's home where she was in duress. Open to prospect of working.
- Social Evaluation at Final-Moved. Still nervous, unhealthy. New set of problems. Responded well to CHRP when she had transportation and was not too ill.
- Current Welfare Duration-6 years.
- Welfare Support-(plus Social Security) initial - $99.86, at final $93.60.
- Intervention-Breathing exercises, counseling and valium, referral to dental clinic and neurosurgeon. (23 contacts).
- Work History/Status-Worked as salesclerk 1951-54.
- Final Staff Evaluation-Age, poor health, lack of skills and work experience suggests poor prognosis for employment. Working at final as babysitter. CHRP moderately helpful.

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- Male, age 38, head of household, lives with wife and 5 children - ages 9, 8, 7, 6, 4; Left school after 9th grade at 16.
- Past Health History-Concussion as child, with ongoing headaches and neck pains. Back pain.
- Presenting Health Problems-Back problem.
- Chief Physical/Psychological findings-Degenerative disk, L3-4, L4-5, spondylosis, L4-5, headaches, speech defect. Beta 79, hypochondriasis at initial 8, at final - not done.
- Social Evaluation at Initial-Shabby, poor hygiene, slow comprehension, illiterate. Frustrated by unemployment, welfare. Unconcerned about health.
- Social Evaluation at Final-not reported.
- Current Welfare Duration-9 years.
- Welfare Support at initial-$548.00, at final - $191.00.
- Intervention-Exercises to strengthen back. Attended sporadically. Referrals to dentist and speech therapist were rejected. Client requested and received intercession with welfare so that he should not have to sell his car. (15 contacts)
- Work History/Status-Graveyard attendant, mason attendant, janitor, laundry sorter, 4 jobs, 4 years employed, last in 1975. Worked briefly as dishwasher in a restaurant while with CHRP.
- Final Staff Evaluation-Highly motivated to work, but not to undergo formal rehabilitation of health problems. Unlikely to succeed at employment without job skills, job counseling.

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- Female, age 24, head of household, 1 child - age 7; 10th grade education, left school pregnant at 16.
- Past Health History-Nerves, lifelong. Headaches and mennorhagia 2 years, abortion, eczema.
- Presenting Health Problems-Severe headaches, stress.
- Chief Physical/Psychological findings-mild anxiety, tension headaches. Beta 104, hypochondriasis at initial 4, at final 2.
- Social Evaluation at initial-Attractive appearance, timid, paranoid, anxiety regarding tension of work relationships.
- Social Evaluation at final-not reported.
- Current Welfare Duration-7 years.
- Welfare Support at initial-$261.00, at final - $291.00.
- Intervention-Psychological and job counseling. Little contact (9 contacts) but tension headaches disappeared, anxiety improved and she registered with SETA for clerical training.
- Work History/Status-Bookkeeper, posting clerk, waitress, beautician training. 4 jobs in 2 years, last worked 1976.
- Final Staff Evaluation-Job training should enhance security regarding employment. She benefitted from CHRP involvement.

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- Female, age 44, head of household, 4 children at home - ages 19, 17, 14, 9; high school graduate.
- Past Health History-Overweight since 1967. Tubal ligation, appendectomy, caesarean sections, repair of incisional hernia, menorrhagia, therapy for menopausal syndrome, herniorraphy, cholecystectomy, anemia, medication and counseling for nerves, anemia.
- Presenting Health Problems-Limitations due to surgery, anemia.
- Chief Physical/Psychological Findings-Hypertension, obesity, anxiety, neuro-eczematoid dermatitis, edema, legs, menopausal syndrome, Beta 104, hypochondriasis at initial 14, at 3 months 17.
- Social Evaluation at Initial-Appropriate dress, hygiene. Unsightly facial blemishes. Tense, worried about health and welfare of children, and so did not want to work full time.
- Social Evaluation at Final-Problems solved by taking part-time employment and adding hours as family adjusted.
- Current Welfare Duration-3 years.
- Welfare Support at initial-$359.00, at final - $0.00.
- Intervention-Hypertension treatment, dermatology evaluation and treatment, referral for evaluation and treatment of anemia, diet and psychological counseling and job counseling , referral for surgical evaluation of hernia. She was not interested in spending time and effort to improve her health. Kept appointments, used medications, but after 2 sessions, rejected weight reduction and psychological counseling. She lost no weight, but her skin cleared quickly. Very responsive to job counseling. (26 contacts)
- Work History/Status-6 jobs as teacher's aide, housekeeper and seamstress in factory. Worked 10 years, last in 1975. Got lunch room job in school while with CHRP.
- Final Staff Evaluation-CHRP was very useful in helping her find work as a companion to persons in housing for elderly, where she continued to promote new clients as she needed. She earned enough (in addition to son's SSI) to get off welfare. Her obesity may cause problems with employment in the future.

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- Female, age 40, head of household, 6 children - ages 19, 18, 15, 14, 12, 11 and infant grandchild; 8th grade education, left school at 16 to get married.
- Past Health History-Recurrent lung infection (sarcoidosis), back pain, 1964 to present, bladder infections and leg pains ongoing, nerves, stomach hernia, hot flashes and insomnia, all ongoing. Eczema.
- Presenting Health Problems-Eczema, back strain, hernia.
- Chief Physical/Psychological findings-Sarcoid, inactive, hiatus hernia, obesity, anxiety, superficial varicosities, scarring, legs. Beta 86, hypochondriasis at initial 6, at final 6.
- Social Evaluation at initial-Appropriate appearance, hygiene good. Very tall, large, tense but good communication. Recent separation from alcoholic husband, fears for children's welfare. Lost teacher's aide job due to severe eczema resulting from marital tensions. Wanted to work again.
- Social Evaluation at final-Time and supportive atmosphere of group counseling improved her emotional status.
- Current Welfare Duration-2 years.
- Welfare Support at initial-$232.00, at final $315.00.
- Intervention-Excellent response to individual and group psychological counseling diet counseling and back exercises. Referred for opthalmologic evaluation and treatment; advocacy for Medicaid approval of glasses. E.N.T. referral for recurrent sore throats; surgical removal of blisters on vocal cords. (32 contacts)
- Work History/Status-Employed as cafeteria help, domestic, teacher's aide, 4 jobs, total duration 9 years. Last worked in 1974.
- Final Staff Evaluation-She had been accepted for OVR training at local handicapped center. CHRP contact had been timely and effective. Excellent prognosis for ongoing employment following training.

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- Female, age 34, head of household, children - ages 13, 12, 7; 9th grade education with high school equivalency diploma.
- Past Health History-Pneumonia as a child with lung scarring and ongoing breathlessness. Dysmennorhea at menarche. Obesity from 1963 to present. Nervousness, onset 1965, diabetes diagnosed 1966. Toxemia of pregnancy, complications of IUD, ankle fracture, psychogenic indigestion, 1962 to present, podalgia and knee pain, 3 years, discomfort from dentures.
- Presenting Health Problems-Diabetes, obesity.
- Chief Physical/Psychological findings-Impaired breathing, obesity, anxiety, ill-fitting dentures, umbilical hernia. Beta 112, hypochondriasis at initial 16, final 3.
- Social Evaluation at Initial-Appropriate dress and hygiene, family problems surrounding recent separation. Desired weight loss, diabetes control, work.
- Social Evaluation at Final-Progress with all problems, weight loss, diabetes control. Had job, registered for secretarial job training, male friend living with her.
- Current Welfare Duration-4 years.
- Welfare Status at initial-$378.00, at final $363.00.
- Intervention-Psychological counseling, weight reduction, breathing exercises, smoking counseling, dental referral, birth control counseling, treatment of scabies. (22 contacts)
- Work History/Status-4 jobs in 7 months' employment, ending 1975. Worked as chambermaid, drycleaner, cashier, sales. Worked 4 months during intervention as school guard full-time, then 3 months part-time. At final, she had registered to begin job training (not WIN or SETA).
- Final Staff Evaluation-CHRP involvement was timely and very effective in helping this person overcome emotional problems and deal with health problems.

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- Male, age 37, head of household. lived with wife and 2-year old son. 1-year old daughter in foster care, visited weekly in home; 8th grade education, dropped out at 16.
- Past Health History-Repair of inguinal hernia as a child and again in 1956 when in the Army where he had onset of back pain and started drinking to excess episodically. Podiatric consultation 1976 for pains in feet and legs.
- Presenting Health Problems-foot and leg problems.
- Chief Physical/Psychological findings-multiple deformities, dyshydrosis, callouses - feet, episodic alcoholism, partially edentulous. Beta 110, hypochondriasis at initial 4, at final 9.
- Social Evaluation at Initial-thin, disheveled, sloppy, poor teeth and hygiene, upset by social services control of his child and his life. Distressed by unemployment.
- Social Evaluation at Final-Problems not resolved, but some improvement in physical health.
- Current Welfare Duration - 1 1/2 years.
- Welfare support at initial-$320.00, at final $428.00 (change of residence)
- Intervention-He was receptive to dental referral for treatment and to orthopedic-podiatric consultation and treatment. He was non-compliant with plans for nutrition counseling and health education. Other agency provided these in home. (17 contacts)
- Work History/Status-4 short jobs as truck driver, mechanic,-10 years self-employed as roofer.- 13 years employed. Health prevented work after 1976.
- Final Staff Evaluation-CHRP only moderately effective in rehabilitation. His limitation due to foot problems is permanent. High motivation to work should make appropriate job training successful.

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- Male, age 30, head of household, lives with wife, children - ages 15, 14, 12, 11, 9; left school at 16 after 9th grade to get married. Had training in small appliance repairs. His wife worked part-time at Rescue Mission.
- Past Health History-Born with enlarged heart, asymptomatic now. Treated for hypertension, 1971, antabuse treatment for alcoholism 1972, surgical drainage of lipoma of back, 1976. Possible torn ligament, at knee, thrombosed hemmorhoids, 1976.
- Presenting Health Problems-Alcoholism, leg problems.
- Chief Physical/Psychological findings-Alcoholism, hypertension, alcoholic hepatitis, torn ligament - right knee, hyperchoteslerolemia. Beta 89, hypochondriasis at initial 22, at final 18.
- Social Evaluation at initial-Intoxicated, alcoholic social environment. Ashamed of problem, motivated to quit and find employment.
- Social Evaluation at final-Same problems, now having family problems also.
- Current Welfare Duration-3 years.
- Welfare Support at initial-$317.92, at final $321.45.
- Intervention-Alcohol counseling and antabuse treatment, diet counseling, hypertension work-up. Three weeks required to stop drinking so antabuse could be started. Dry 4 1/2 months, seeking employment. Drinking after case dosed at 3 months, and client referred to family medicine center. (26 contacts)
- Work History/Status-3 jobs, cleaner, janitor, truck driver, employed 6 years, last in 1968. Short employment during rehab as laborer.
- Final Staff Evaluation-CHRP intervention very effective but all involved recognized need for long-term treatment.

- Female, age 52, head of household, 3 children - ages 20, (worked, no contribution to support) 13, 11, and male friend, unemployed, not on P.A.
- Past Health History-Appendectomy, broken leg - 1971, broken arm - 1974, menopausal syndrome and indigestion - 1974 to present, suicide attempt-1975.
- Presenting Health Problems-female problems.
- Chief Physical/Psychological findings-Menopause, situational anxiety, obesity, dorsal kyphosis, dermatitis, breasts. Beta 100, hypochondriasis score at initial 6, final - not done.
- Social Evaluation at initial-Appropriate behavior, shabby, obese, fair hygiene. Problems with children.
- Social Evaluation at final-Non-compliant, no treatment.
- Current Welfare Duration-15 years.
- Welfare support at initial-$204.48, at final - $152.90.
- Intervention-Recommended were weight reduction and family counseling . Reluctant compliance for 3 months then passive rejection. (13 contacts, 7 of which were requests for compliance)
- Work History/Status-Lunch aide, bakery worker, salesclerk, factory stapler, inspector. 5 jobs, 3 1/2 years worked, working as lunch aide at entry, then as clerk in bakery.
- Final Staff Evaluation-Unable to contact her for follow-up. CHRP seemingly ineffectual in producing health improvement. She seemed determined to work, and able to find a job.

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- Female, age 44, head of household, 2 children - ages 15, 12; high school graduate.
- Past Health History-Stated she had had malaria as a child with annual recurrence of symptoms until age 25. Chronic paranoid schizophrenia - 13 years, treated medically, hospitalized 1976, lifelong constipation. Hysterectomy - 1967 as fertility control. Obesity, +50 lbs. in 1975.
- Presenting Health Problems-nerves.
- Chief Physical/Psychological findings-Chronic paranoid schizophrenia, massive obesity, borderline hypertension, sickle-cell trait. Beta 95, hypochondriasis at initial 8, at final 18.
- Social Evaluation at initial-Fair hygiene and appearance, pleasant. Related problems with children, landlord, unpaid bills. Religious. Currently in outpatient status at psychiatric hospital. Motivated to improve her condition and to work.
- Social Evaluation at final-Unavailable for regularly scheduled group counseling. Well accepted by others in group, but lacks coping mechanisms for stress.
- Current Welfare Duration-9 years.
- Welfare Support at Initial-unknown, at final 0 (reason unknown)
- Intervention-Weight reduction and diet counseling - showed for 3 sessions out of 7. Group psychological counseling - see above (14 contacts).
- Work History/Status-Home aide, cashier, elevator operator, record clerk. 5 jobs, for total duration of 8 weeks. Last worked 1973. Took night maintenance job in facility housing CHRP (referred for it by CHRP). Absenteeism caused her dismissal after 1 week.
- Final Staff Evaluation-No goals for rehab were reached. She is a poor prospect for employment. At case closure, she was continuing therapy at psychiatric center.

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- Male, age 24, head of household, lived with wife, 3 children - ages 6, 3, 1; dropped out of school after 8th grade at 16.
- Past Health History-Appendicitis as a child. Bursitis shoulders-1975-injected 1x, did not follow up. Nerves since 1975. Low back pain, onset 1976.
- Presenting Health Problems-Bursitis.
- Chief Physical/Psychological findings-Anxiety, mild, low back syndrome, arm pain, bilateral, dental caries. Beta 76, hypochondriasis at initial 20, at final 20.
- Social Evaluation at initial-Appropriate dress and hygiene, tense. Motivated to work but saw health problems as severe and work-limiting.
- Social Evaluation at final-Denied emotional element of health problems. Rejected counseling . Hostile re: CHRP involvement.
- Current Welfare Duration-3 years.
- Welfare Support at initial-$466.00, at final $428.00.
- Intervention-Recommended: Psychological counseling; relaxation techniques, x-rays - shoulders, arms, back exercises, dental care. X-rays negative. Attended 2 exercise sessions under duress. No dental treatment. Was mandated to return (by welfare). (14 contacts)
- Work History/Status-6 jobs, as produce manager, supermarkets, assistant manager, gas stations, security guard. 5 years employment, last worked 1975.
- Final Staff Evaluation-Discrepancy between stated desires for relief of bursitis and pursuit of same.(He had not pursued course of treatment of bursitis in 1976.) No evidence of problem on x-ray.

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- Male, age 27, head of household, lived with pregnant wife and 2 children - ages 2, 1; suspended from school after 9th grade, age 15, because of behavior.
- Past Health History-Asthma as child, also neck injury and possible shoulder fracture with subsequent arthritis ongoing. Hiatal hernia as adult, car accident - back spasms, nerves for which he was hospitalized, obesity.
- Presenting Health Problem-Nervous condition.
- Chief Physical/Psychological findings-Hiatus hernia, obesity, mild hypertension, varicose veins, left leg, anxiety. Beta 96, hypochondriasis at initial 24, final - not done.
- Social Evaluation at initial-Appropriate dress and hygiene, concerned with nerves and 110 lb. weight gain in the Marines for which he was discharged, ending his career plan. Phobia about death and dying.
- Social Evaluation at final-not done.
- Current Welfare Duration-2 years.
- Welfare Support at Initial-$469.70, at final $0.00.
- Intervention-Recommended: High school equivalency, psychological counseling, weight reduction. Attended 1 session each of counseling and weight reduction. (8 contacts).
- Work History/Status-Laborer in foundry. 4 jobs in 3 years. Last worked in 1976. Found work in foundry 7 months after evaluation.
- Final Staff Evaluation-He did not perceive his need for CHRP services. With weight loss, he could re-enter Marines, or enter job training.

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- Female, age 30, head of household, lives with her child - age 8 and her brother, 19, who works and contributes support.
- Past Health History-As a child, knee injury with surgical repair and resultant arthritis, ongoing, severe strep throat, tonsillitis, lifelong obesity, diabetes, irregular menses, anencephalic child, hypercholesterolemia, 9 abortions.
- Presenting Health Problem-obesity.
- Chief Physical/Psychological findings-massive obesity, diabetes mellitus, degenerative arthritis - knee, hypercholesterolemia. Beta 112, hypochondriasis at initial 6, at final 16.
- Social Evaluation at Initial-Appropriate appearance, behavior. Highly work-motivated. Does not see weight or arthritis as limiting job goal of nurse-aide despite doctor's advice. Long term marital stress, recent separation. Positive outlook.
- Social Evaluation at final-Excellent cooperation. Lack of weight loss indicative of self-destructive tendency. Progress on personal problems.
- Current Welfare Duration-3 years.
- Welfare Support at initial-$260.00, at final $191.20.
- Intervention-Weight reduction, group counseling. (23 contacts)
- Work History/Status-5 jobs as domestic, home aide, waitress, day care mother. 4 1/2 years employment. Last worked in 1975. Had nurse's aide training through manpower program prior to entry.
- Final Staff Evaluation-Massive obesity, is work-limiting. CHRP efforts toward weight reduction not successful.

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- Female, age 40, lives with her married pregnant daughter and her husband who both work, their child age 6 and her 3 children, 17, 11, 7; 8th grade education-left school to work.
- Past Health History-As a child, she received burns of her back requiring skin graft. As adult, she had an ovarian cyst removed in 1961, a punctured eardrum with hearing loss, ectopic pregnancy, joint pains, nerves and depression, and insomnia.
- Presenting Health Problems-Depression, fatigueability, partial hearing loss.
- Chief Physical/Psychological Findings-Anxiety depression, scars, back, hearing loss - right ear, obesity, vaginitis, joint pains, osteochondroma, right elbow. Beta 98, hypochondriasis at initial 20, at final - not done.
- Social Evaluation at Initial-Social isolation, crowded home, family tensions, lacks stimulation. Motivated to work, job skills limited. Also wants high school equivalency. She had a realistic appraisal of problems.
- Social Evaluation at Final-Status essentially unchanged. Expressed interest in job training for keypunch operator.
- Current Welfare Duration-16 1/2 years.
- Welfare Support at initial-$248.84, at final - $137.50. Reason for change not known.
- Intervention-Counseling for anxiety depression. Weight reduction, evaluation and treatment of joint pains and hearing loss. Excellent response for 1 month with improvement of mood and 6 lb. weight loss, after which she failed to come and could not be reached. Referred to Health Department Indian Reservation caseworker for followup. (6 contacts, 15 attempted contacts)

- Work History/Status-3 jobs, housekeeping, food service worker, factory, duration 1 1/2 months, last worked in 1977.
- Final Staff Evaluation-CHRP intervention only temporarily helpful.

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- Female, age 39, head of household, 3 children - ages 12, 11, 8; dropped out of school after 8th grade. Now has high school equivalency.
- Past Health History-Nervous condition for which she was hospitalized, miscarriage, dysmennorhea, cramps behind knees, sporadic.
- Presenting Health Problem-Nervous condition.
- Chief Physical/Psychological Findings-Emotional disorder, functional heart murmur, neurodermatitis. Beta score 92, hypochondriasis at initial 7, at final 2.
- Social Evaluation at Initial-Inappropriate appearance, excited, hyperactive, suspicious, depressed. Hysterical personality. Lived 3 years in reformatory as a teenager. In psychiatric treatment at entry, also on probation for theft.
- Social Evaluation at Final-Some improvement in her social-emotional behavior. Habituated to life problems. Still needed help.
- Current Welfare Duration-10 1/2 years.
- Welfare Support at initial-$428.00, at final-$258.00.
- Intervention-Psychological counseling. Attendance was made a stipulation by the probation counselor. She cooperated at first, but after 3 months, attendance was sporadic. (20 contacts)
- Work History/Status-3 jobs, as nurse-aide, riveter and factory seamstress. She worked for 1 year, 9 months, last in 1968.
- Final Staff Evaluation-CHRP intervention was minimally successful here. She needs intensive psychiatric help with socialization skills before considering employment.

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- Female 32, head of household, 3 children-ages 11, 9, 7; left school after 8th grade at 14, pregnant.
- Past Health History-Hospitalized for syncope, age 8. Headaches, onset in teens, neuro dermatitis, onset 1967, total hysterectomy 1972 for P.I.D. Repair incisional hernia 1973. Peptic ulcer treated medically 1974. Tonsillectomy 1974. Viral hepatitis 1976-77.
- Presenting Health Problems-Headaches, skin problems.
- Chief Physical/Psychological Findings-tension headaches, mild anxiety, chronic neurodermatitis, aggravated by night-scratching. Beta score 93, hypochondriasis at initial 11, at final 9.
- Social Evaluation at Initial-Attractive appearance and behavior. Stated she had been fired from job due to fainting spells. Currently instigating Human Rights suit. Also in counseling for family problems. Wanted counselling, job or job training.
- Social Evaluation at Final-Coping adequately with problems. Seeking employment.
- Current Welfare Duration-3 1/2 years.
- Welfare Support at initial-$382.64, at final $281.20.

- Female, age 30, head of household, lives with her child - age 8 and her brother, 19, who works and contributes support.
- Past Health History-As a child, knee injury with surgical repair and resultant arthritis, ongoing, severe strep throat, tonsillitis, lifelong obesity, diabetes, irregular menses, anencephalic child, hypercholesterolemia, 9 abortions.
- Presenting Health Problem-obesity.
- Chief Physical/Psychological findings-massive obesity, diabetes mellitus, degenerative arthritis - knee, hypercholesterolemia. Beta 112, hypochondriasis at initial 6, at final 16.
- Social Evaluation at Initial-Appropriate appearance, behavior. Highly work-motivated. Does not see weight or arthritis as limiting job goal of nurse-aide despite doctor's advice. Long term marital stress, recent separation. Positive outlook.
- Social Evaluation at final-Excellent cooperation. Lack of weight loss indicative of self-destructive tendency. Progress on personal problems.
- Current Welfare Duration-3 years.
- Welfare Support at initial-$260.00, at final $191.20.
- Intervention-Weight reduction, group counseling. (23 contacts)
- Work History/Status-5 jobs as domestic, home aide, waitress, day care mother. 4 1/2 years employment. Last worked in 1975. Had nurse's aide training through manpower program prior to entry.
- Final Staff Evaluation-Massive obesity, is work-limiting. CHRP efforts toward weight reduction not successful.

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- Female, age 40, lives with her married pregnant daughter and her husband who both work, their child age 6 and her 3 children, 17, 11, 7; 8th grade education-left school to work.
- Past Health History-As a child, she received burns of her back requiring skin graft. As adult, she had an ovarian cyst removed in 1961, a punctured eardrum with hearing loss, ectopic pregnancy, joint pains, nerves and depression, and insomnia.
- Presenting Health Problems-Depression, fatigueability, partial hearing loss.
- Chief Physical/Psychological Findings-Anxiety depression, scars, back, hearing loss - right ear, obesity, vaginitis, joint pains, osteochondroma, right elbow. Beta 98, hypochondriasis at initial 20, at final - not done.
- Social Evaluation at Initial-Social isolation, crowded home, family tensions, lacks stimulation. Motivated to work, job skills limited. Also wants high school equivalency. She had a realistic appraisal of problems.
- Social Evaluation at Final-Status essentially unchanged. Expressed interest in job training for keypunch operator.
- Current Welfare Duration-16 1/2 years.
- Welfare Support at initial-$248.84, at final - $137.50. Reason for change not known.
- Intervention-Counseling for anxiety depression. Weight reduction, evaluation and treatment of joint pains and hearing loss. Excellent response for 1 month with improvement of mood and 6 lb. weight loss, after which she failed to come and could not be reached. Referred to Health Department Indian Reservation caseworker for followup. (6 contacts, 15 attempted contacts)

- Work History/Status-3 jobs, housekeeping, food service worker, factory, duration 1 1/2 months, last worked in 1977.
- Final Staff Evaluation-CHRP intervention only temporarily helpful.

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- Female, age 39, head of household, 3 children - ages 12, 11, 8; dropped out of school after 8th grade. Now has high school equivalency.
- Past Health History-Nervous condition for which she was hospitalized, miscarriage, dysmennorhea, cramps behind knees, sporadic.
- Presenting Health Problem-Nervous condition.
- Chief Physical/Psychological Findings-Emotional disorder, functional heart murmur, neurodermatitis. Beta score 92, hypochondriasis at initial 7, at final 2.
- Social Evaluation at Initial-Inappropriate appearance, excited, hyperactive, suspicious, depressed. Hysterical personality. Lived 3 years in reformatory as a teenager. In psychiatric treatment at entry, also on probation for theft.
- Social Evaluation at Final-Some improvement in her social-emotional behavior. Habituated to life problems. Still needed help.
- Current Welfare Duration-10 1/2 years.
- Welfare Support at initial-$428.00, at final-$258.00.
- Intervention-Psychological counseling. Attendance was made a stipulation by the probation counselor. She cooperated at first, but after 3 months, attendance was sporadic. (20 contacts)
- Work History/Status-3 jobs, as nurse-aide, riveter and factory seamstress. She worked for 1 year, 9 months, last in 1968.
- Final Staff Evaluation-CHRP intervention was minimally successful here. She needs intensive psychiatric help with socialization skills before considering employment.

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- Female 32, head of household, 3 children-ages 11, 9, 7; left school after 8th grade at 14, pregnant.
- Past Health History-Hospitalized for syncope, age 8. Headaches, onset in teens, neuro dermatitis, onset 1967, total hysterectomy 1972 for P.I.D. Repair incisional hernia 1973. Peptic ulcer treated medically 1974. Tonsillectomy 1974. Viral hepatitis 1976-77.
- Presenting Health Problems-Headaches, skin problems.
- Chief Physical/Psychological Findings-tension headaches, mild anxiety, chronic neurodermatitis, aggravated by night-scratching. Beta score 93, hypochondriasis at initial 11, at final 9.
- Social Evaluation at Initial-Attractive appearance and behavior. Stated she had been fired from job due to fainting spells. Currently instigating Human Rights suit. Also in counseling for family problems. Wanted counselling, job or job training.
- Social Evaluation at Final-Coping adequately with problems. Seeking employment.
- Current Welfare Duration-3 1/2 years.
- Welfare Support at initial-$382.64, at final $281.20.

- Intervention-Counselling for anxiety and headaches. Dermatology consult. Good participation for 2 months, then ad-lib counselling. No improvement in skin condition. (14 contacts)
- Work History/Status-3 jobs, daycare aide, school aide, cashier. 15 months employment, last worked 1976.
- Final Staff Evaluation-Benefited from intervention emotionally. Now studying for high school equivalency, actively job-hunting.

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- Female, age 41, head of household, 2 children - ages 12, 6 live with her; dropped out of school after 10th grade.
- Past Health History-E.N.T. Surgery, 1964 for otosclerosis - right ear, tuberculosis 1967. Cholecystectomy 1972, amenorrhea, D & C 1975, hypermenorrhea 1976. Premenstrual headaches.
- Presenting Health Problems-Menorrhagia, dysmenorrhea.
- Chief Physical/Psychological Findings-Menorrhagia, menstrual headaches, otosclerosis, marked obesity. Inactive tuberculosis. Six children. Beta score 106, hypochondriasis at initial 9, at final 10.
- Social Evaluation at Initial-Appropriate appearance and behavior. Depressed, concerned about health problems. Interested in factory work following rehabilitation.
- Social Evaluation at Final-not done.
- Current Welfare Duration-1 year.
- Welfare Support at initial-$287.24, at final $340.00.
- Intervention-Referrals for evaluation and treatment of GYN problems, hearing problems. Diet counseling and weight reduction. Her progress and cooperation were good. 5 1/2 lb. weight loss, menorrhagia, headaches decreased. Will continue GYN therapy, will have ENT surgery soon for left ear otosclerosis. (25 contacts)
- Work History/Status-One unskilled job in factory 2 months in 1977. Menstrual problems caused her to quit.
- Final Staff Evaluation- Intervention may prove very beneficial. Good candidate for job skills training after rehabilitation is complete.

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- Male, age 39, head of household, lives with wife and 3 children - ages 5, 4, 2; left school after 6th grade to work.
- Past Health History-Hospitalized 1969, stab wound; epilepsy and hypertension diagnosed in 1976. Alcoholism.
- Presenting Health Problems-History of epilepsy.
- Chief Physical/Psychological Findings-Alcoholism, alcoholic hepatitis, seizures, cerebral atrophy, mild hydrocephalis, hypertension, arcus senilis proteinuria, polycythemia. Beta score 60, hypochondriasis at initial 12, at final 10.
- Social Evaluation at Initial-Appropriately dressed, untidy. Poor historian, confused. Denied alcohol problem.
- Social Evaluation at Final-Self-image markedly better after alcohol rehab.
- Current Welfare Duration-4 1/2 years.
- Welfare Support at initial-$318.00, at final $318.00.
- Intervention-Referral for detoxification, antabuse treatment. Evaluation of seizures, discontinued Dilantin (seizures suspected to be of alcoholic origin). Hypertension probably due to chronic alcohol intake. Antabuse continued on out-patient basis through CHRP. Some job and personal counseling, referral to alcohol out-patient unit. (20 contacts)

- Work History/Status-Farm laborer in Alabama 12 years, trash collector, 12 years. Lost job at onset of epileptic seizures 1975.
- Final Staff Evaluation-At final, client actively seeking employment through WIN. Off antabuse, drinking some again. CHRP a definite boon to his employability. An immediate job is necessary to continued rehab benefits.

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- Female, age 31, 2 children ages 9,7; dropped out of school at 16 after 6th grade to go to work.
- Past Health History-Congenital strabismus, corrected by surgery; appendectomy 1973; elective abortion 1974; anxiety onset 1974; ongoing medication.
- Presenting Health Problems-nerves
- Chief Physical/Psychological Findings-Moderate anxiety, partially edentulous, vaginitis. Beta score 77, hypochondriasis at initial 13, at final-not done.
- Social Evaluation at Initial-Appearance disheveled, fair hygiene, mismatched clothing. Emotionally unstable, distressed. Fixation re: husband's death 7 years previous. Social isolation. Poor verbal/educational skills and understanding.
- Social Evaluation at Final-No participation in counseling; planned to develop socialization skills. No final evaluation for social problems.
- Current Welfare Duration-6 years.
- Welfare Support at initial-$186.00, at final $176.00 plus social security.
- Intervention-Counseling recommended also high school equivalency and dental treatment. No participation. (4 contacts)
- Work History/Status-Never worked. No job skills.
- Final Staff Evaluation-Non-compliant. Receives only medication for anxiety. Will need emotional support and therapy if she is to be employable.

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- Female, age 38, on Home Relief, lived with 4 female friends all in their 20's, all in school.
- Past Health History-Spondylolysis, onset 1975, treated first by osteopath, then a chiropractor.
- Presenting Health Problems-Back problems.
- Chief Physical/Psychological Findings-Spondylolysis, obesity, bilateral carpal tunnel syndrome, sacralization - L-5 vertebra. Beta - not done. Hypochondriasis at initial 4, at final 8.
- Social Evaluation at Initial-Pleasant, seemed intelligent, sophisticated. Highly motivated to find employment or re-training suitable to employment within her physical limitations. Concerned with inability to secure RN documentation from India through Albany.
- Social Evaluation at Final - not done. Unavailable.
- Current Welfare Duration-10 months.
- Welfare Support at initial-$192.00, at final $0.00.
- Intervention-Diet counseling; back exercises, job and education counseling. Pursuit of job prevented full attendance, but cooperation produced weight loss. Back problem unchanged, summer job deterred rehab. Produced exhaustion, foot problem. (13 contacts)
- Work History/Status-Private duty nurse, 1961, India. Charge nurse 12 years - Bombay hospital. Private duty in U.S. - 1974-76. Had placed 40 job applications. Worked as nurse in summer camp during CHRP involvement. Sought OVR support for Voc. Ed.
- Final Staff Evaluation-CHRP helpful in weight reduction, vocational counseling. She is resourceful and will succeed if she can avoid strenuous nursing.

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- Male, age 34, on Home Relief, lives with friend on unemployment insurance; dropped out of school after 8th grade, age 16.
- Past Health History-Tonsillectomy as a child. Repair fracture - right leg resulting from auto accident - 1962. Alcohol and drug abuse, with hospitalization for 1 year - 1964-65 and again in 1976. Surgical removal of part of leg pin prior to CHRP entry.
- Presenting Health Problems-Recent surgery, nervousness, alcoholism.
- Chief Physical/Psychological Findings-Illiterate, limitation of right leg due to surgery, bilateral hallux valgus, dental caries (restorations in progress) history of alcoholism, drug abuse. Beta score 97, hypochondriasis at initial 12, at final 25.
- Social Evaluation at Initial-Appropriate dress and hygiene, nervous but friendly, eager. Limps. Extensive drug and alcohol history, prison record. Motivated to seek development of artistic talents, recognized need to upgrade literacy skills. In ongoing counseling (4 years).
- Social Evaluation at Final-Procrastinated re-entry into literacy program. Needed improved self-discipline. Intended to find a job.
- Current Welfare Duration-3 years.
- Welfare Support at Initial-unknown, at final - unknown.
- Intervention-Vocational counseling cued referral for literacy training. In project 5 months, most contacts by phone. Put off entry in Literacy Volunteers prior to surgery, and while out of town to evade police. Had made no contact at case closure. (14 contacts)
- Work History/Status-Self-employed as barber, age 19, until accident. Also had worked 1 year as farm laborer, 2 months in construction. No work after accident, 1962.
- Final Staff Evaluation-Has potential for employment but would require intensive retraining of habits regarding achievement.

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- Female, age 49, lives with her 3 children - ages 17, 16, 13 and 2 grandchildren - ages 6 and 5 who receive child support. High school graduate with training in computer operation.
- Past Health History-Anxiety - 27 years. Obesity - 1965 ongoing. 10 pregnancies, 7 children, hysterectomy for fibroid uterus - 1969, hypertension - 1970, neurodermatitis - back, hand pain - 1976.
- Presenting Health Problems-Hypertension, dermatitis.
- Chief Physical/Psychological Findings-Hypertension, pain - right thumb, obesity, neurodermatitis - back, dental caries, periodontal disease, non-deficient anemia, cystic lesion - left lower eyelid. Beta score 111, hypochondriasis at initial 7, at final 5.
- Social Evaluation at Initial-Appropriate dress and hygiene, nervous - head shook. Realistically concerned with health problems which caused loss of job. In vocational evaluation/WIN. Dissatisfied with present health care.
- Social Evaluation at Final-Improvement in problem solving. Continued motivation to work.
- Current Welfare Duration-2 1/2 years.
- Welfare support at initial-$428.00, at final $0.00 - moved out of county.
- Intervention-Consultations and treatment - neurodermatitis, dental problems, anemia, hand, cyst eyelid. Weight reduction, counseling. She was very cooperative throughout, but failed to lose weight. (24 contacts)

- Work History/Status-3 jobs, data processing, factory work, clerical. Employed 5 1/2 years, last worked in 1976.
- Final Staff Evaluation-CHRP involvement encouraged solution of some health problems and provided insights for improved health care in future.

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- Female, age 37, head of household, 3 children - ages 14, 12, 11. 5th grade education in Puerto Rico. Left school as she was needed at home.
- Past Health History-Pneumonia age 7, hospitalized age 11 for head injuries resulting from beating. Varicose veins for 24 years. 10 pregnancies - 6 children, hysterectomy 1972, prolapsed uterus. Hypertension, arthritis, anxiety 1976 in counseling.
- Presenting Health Problems-High blood pressure, nerves.
- Chief Physical/Psychological Findings-Anxiety, varicose veins, obesity, mild hypertension, joint pains, dental caries, degenerative arthritis, dorsal spine. Beta score - not done. Hypochondriasis at initial 24, at final 12.
- Social Evaluation at Initial-Appropriate dress and hygiene, tense. Spoke only Spanish, had interpreter. 10 years in U.S. Numerous health complaints, dissatisfied with medical care. Not interested in employment. Problems with children.
- Social Evaluation at Final-Followed pattern of previous counseling: Sought tranquilizers but lacked motivation and insight for more in-depth efforts.
- Current Welfare Duration-1 1/2 years.
- Welfare Support at initial-$378.00, at final $428.00.
- Intervention-Evaluated and coordinated health care, instigated dental repair. Prescribed elastic stockings. Weight reduction, referred for nutrition aide. Recommended group counseling to improve socialization skills. Attendance at weight reduction and groups poor. No weight loss. (21 contacts)
- Work History/Status-none, no job skills.
- Final Staff Evaluation-Intervention of little benefit to employability due to communication problems and lack of motivation and insights for change or employment.

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- Female, age 34, head of household, 3 children - ages 13, 11, 10; left school at 16 after 8th grade as she was needed at home.
- Past Health History-Nerves, anxiety since 1962. Car accident, back pain 1962. Varicose veins 1965. Phlebitis, treated in 1976.
- Presenting Health Problem-low back strain.
- Chief Physical/Psychological Findings-Varicose veins, dental caries, vertebrogenic pain syndrome, anxiety, neurosis, episodic alcoholism. Beta score 83, hypochondriasis at initial 23, at final 20.
- Social Evaluation at Initial-Appropriate appearance, anxious, muffled speech. Problems with children. Family social worker currently counselling at home. Few social contacts outside home. Pre-occupied with family, health problems, rejected idea of work prior to their solution.
- Social Evaluation at Final-Irregular attendance for counseling. Family problems took precedence. No change seen.
- Current Welfare Duration-7 1/2 years.
- Welfare Support at initial-$428.00, at final $350.00.

- Intervention-Health education, back exercises, dental care, support hose prescribed. Little cooperation with any recommendations. (11 contacts)
- Work History/Status-none. No job skills.
- Final Staff Evaluation-Physically able to work, avoiding standing, stooping, bending. No apparent desire to improve health. Should be referred to psychiatric outpatient facility for correction of sick role behavior, problem solving and parenting skills.

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- Female, age 42, lived with child age 16 and male friend, employed and contributing to household support. Left school at 16, completing 10th grade.
- Past Health History-Removal of ovarian cysts as teenager. Edema - legs, 1953 ongoing. Toxemia of pregnancy 1967. Hypertension 1971. 10 pregnancies - 9 children.
- Presenting Health Problem-High blood pressure.
- Chief Physical/Psychological Findings-Obesity, borderline hypertension, varicose veins. Beta score 94, hypochondriasis at initial 15, at final 20.
- Social Evaluation at Initial-Neat, appropriate appearance, congenial. 4 children in foster homes. Stated she could not afford to keep them. Unable to hold job as receptionist in WIN office due to leg swelling. Primary concerns, daughter, health, employment. Motivated to work.
- Social Evaluation at Final-Utilized counselling very well. Improved problem-solving ability.
- Current Welfare Duration-2 1/2 years.
- Welfare Support at initial-$273.74, at final $280.00.
- Intervention- Recommended were weight reduction, support hose, hypertension control, exercise program. Excellent response, but lost no weight. Hypertension treated initially, normal without medication at final. She concluded intervention at 6 months as she had a babysitting job. (22 contacts)
- Work History/Status-1 job, receptionist, WIN office 1976, 3 months.
- Final Staff Evaluation-Employable full time, no limitations. Weight loss would lessen hazard of repeated edema. Good motivation to work, needed job counselling.

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- Female, age 22, on Home Relief, lived alone. High school graduate; nurse's aide training (Job Corp)
- Past Health History-Suicide attempt as high school student. D & C plus several emergency room visits 1974-77 for menorrhagia, hypothryoidism, insomnia, headaches.
- Presenting Health Problems-Hypothyroidism, uterine bleeding.
- Chief Physical/Psychological Findings-Obesity, sick role behavior, anxiety depression. Beta score 95, hypochondriasis at initial 17, at final - not done.
- Social Evaluation at Initial-Appropriate appearance. Flattened affect. Many somatic complaints. History of visual hallucinations - counseling following suicide attempt. Long work history, interrupted repeatedly by menstrual problems.
- Social Evaluation at Final-No evidence of impetus for change. Resented CHRP health advocacy. Arrested once while involved with CHRP (reason not known).

- Current Welfare Duration-16 months.
- Welfare Support at initial-$211.00, at final $211.00.
- Intervention-Recommended: Medical investigation of course of menorrhagia, hypothyroidism, headaches. Weight reduction, individual counselling. Attended 1 weight reduction session, stated she wanted diet pills. Valium prescribed at client's request, for anxiety.
- Work History/Status-5 jobs, nurse's aide, teacher's aide, assembler/factory, sales. Employed 5 years, last worked in 1975.
- Final Staff Evaluation-No objective evidence of benefit. Arrest required consideration of possible drug involvement.

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- Female, age 26, on Home Relief, lived alone; left school at 11 after 6th grade, stated she got sick.
- Past Health History-Rheumatic fever and burns - right leg as a child, hypertension, diagnosed, 1974, fractured finger - right hand 1975. 4 miscarriages.
- Presenting Health Problems-Hypertension, history of rheumatic fever, obesity.
- Chief Physical/Psychological Findings-Hypertension, obesity, chronic rheumatic carditis, late effects, injury - right forefinger, lt. ventricular cardiac enlargement, anxiety depression. Beta score 83, hypochondriasis at initial 13, at final - not done.
- Social Evaluation at Initial-Appropriate appearance, cited boredom, loneliness, inactivity, stated interest in job training, counseling and weight reduction.
- Social Evaluation at Final-Interest never materialized. Attendance sporadic, she was incommunicative. Away from home daytimes when sought after.
- Current Welfare Duration-2 years.
- Welfare Support at initial-unknown, at final $211.00.
- Intervention-Recommended: Weight reduction, low calorie, low sodium diet, surgical evaluation, finger, counselling. Came for weight group twice, counseling once. Returned post intervention questionnaire with request for referral for help with health. (6 appearances, 15 contacts)
- Work History/Status-4 jobs - 1 as maid, 3 as machine operator/factory. Employed 7 1/2 years, last in 1974.
- Final Staff Evaluation-CHRP involvement was untimely and ineffective.

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- Female, age 26, on Home Relief, lives with male friend who works and contributes to expenses. She completed 10th grade, dropping out at 17 because she was a slow learner.
- Past Health History-Stuttering since age 5, treated at speech clinic. Emotional tension, onset 1975. Severe headaches attributed to anger - 2-3 months.
- Presenting Health Problems-Speech difficulty, emotional tension.
- Chief Physical/Psychological Findings-Stuttering, cerumen - left ear. Beta 95, Hypochondriasis at initial 1, at final 5.
- Social Evaluation at Initial-Appropriate appearance, braces on teeth. Stuttering - mild to moderately severe. Tense. Stated speech therapy at 11 and 17 produced intolerable anxiety. Highly motivated to work. In adult basic education course, would like college, human studies.

- Social Evaluation at Final-Good progress in dealing with tension through relaxation techniques. Defined vocational goals.
- Current Welfare Duration-8 months.
- Welfare Support at initial-$184.50, at final $206.66.
- Intervention-Counseling and hypnosis (not covered by Medicaid, therapy was donated), training in relaxation techniques. Removal of ceruman ear. Cooperation with hypnotherapy temporary (5 visits) Able to use relaxation skills; stuttering reduced. Client was assisted to seek entry at community college for nursery school teacher's training. (16 contacts)
- Work History/Status-5 jobs, salesclerk, kitchen, counter help, daycare, office clerk. Employed sporadically for 1 1/2 years - 1970-76.
- Final Staff Evaluation-Intervention was beneficial in teaching coping techniques to reduce tension and stuttering, and in directing vocational course.

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- Female, age 26, lived alone. 3 Children - ages 6, 2, 1 in foster care. Dropped out of school after 10th grade.
- Past Health History-Skull fracture, insertion of metal plate - 1970; miscarriage.
- Presenting Health Problems-Obesity.
- Chief Physical/Psychological Findings-Obesity, anxiety depression, episodic alcohol abuse, dental caries. Beta score 103, hypochondriasis at initial 5, at final 12.
- Social Evaluation at Initial-Depressed affect, memory disoriented. In foster home until 14. Problems with relationships, tensions, alcohol, health. Stated interest in rehabilitation and employment.
- Social Evaluation at Final-No change. Apparently consumed by stress of life problems, precluding investment in rehab.
- Current Welfare Duration-6 years.
- Welfare Support at initial-unknown, at final-unknown (figures not available from DSS)
- Intervention-Recommended: Weight reduction, counseling, health education. Cooperated with evaluation procedures, but cancelled or missed all intervention appointments. Responded to post-intervention questionnaire with request for referral for help with problems. (13 attempts without contact, 11 contacts)
- Work History/Status-3 jobs as housekeeper for 5 months in 1972.
- Final Staff Evaluation-Apparently recognizes need for intensive support in self-development.

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- Male, age 29, head of household, lived with wife, 6 children - ages 8, 6, 5, 4, 3, 1; left school at 16 after 9th grade to enter military service. In night school for business management and high school diploma.
- Past Health History-Hospitalized 1967 for service-connected back injury. Pneumonia and bronchitis - hospitalization 1976. Obese all his life - 75 lb. weight gain since 1975.
- Presenting Health Problems-Service connected back injury.
- Chief Physical/Psychological Findings-Low back pain, obesity, dental caries. Beta score - 124, hypochondriasis at initial 22, at final - not done.
- Social Evaluation at Initial-Appropriate appearance, behavior. Lacked confidence that he could get or hold a job. Felt victimized by others. Complained about inadequacy of housing. Dubious motivation for change. OVR affiliation - 1974 - uncooperative, unmotivated. OVR rejected 1977 application.
- Social Evaluation at Final-No change.

- Current Welfare Duration-7 years.
- Welfare Support at initial-$635.00, at final - $575.00 plus $38.00/mo. VA support.
- Intervention-Recommended: Weight reduction, diet counseling; exercises. Attended one weight reduction appointment, then cancelled or missed all others. Asked for diet plan. Much family involvement. (8 contacts, 6 additional attempts/CHRP)
- Work History/Status-5 jobs, general factory work, barber. Worked for 9 months - 1969-70.
- Final Staff Evaluation-Uncooperative, unmotivated to change or work.

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- Male, age 28, lived with wife and children - ages 6, 5. Dropped out of school after 10th grade at 17. Manpower mechanic training.
- Past Health History-Prematurity, developed pneumonia. Injury to knee as a child, obesity - 8 years. History of heavy smoking (4 packs/day), cholecystectomy - 1976.
- Presenting Health Problems-Obesity.
- Chief Physical/Psychological Findings-Low back pain. Beta score 74, hypochondriasis at initial 18, at final 14.
- Social Evaluation at Initial-Impaired literacy skills, lack of job skills. Has legal and many personal problems (dependency on deceased mother and health problems. Sick role behavior and somatic complaints). Extreme nervousness during interview. Desire for literacy, job skills.
- Social Evaluation at Final-Improvement of many problems. Compliant, with increasing enthusiasm after dental treatment improved his appearance.
- Current Welfare Duration-5 years.
- Welfare Support at Initial-$176.00, at final - $201.00.
- Intervention-Weight reduction, health education, psychological counseling; dental treatment. Desultory cooperation with diet plans - unable to change eating habits during intervention but still trying at final. Back pain persisted. (13 contacts)
- Work History/Status-2 jobs, lineman in foundry, delivery. Employed 9 months between 1972-76.
- Final Staff Evaluation-Intervention moderately helpful. Needs long-term intensive counseling, continued weight reduction, and employment counseling. Referral made and implemented for adult basic education.

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- Male, age 23, lives with wife, 10 month infant; high school graduate.
- Past Health History-Umbilical hernia as a child, acne and obesity.
- Presenting Health Problem-Obesity.
- Chief Physical/Psychological Findings-Obesity, pustular acne, borderline hypertension. Beta score 109, hypochondriasis at initial 2, at final 5.
- Social Evaluation at Initial-No problems other than concern with obesity which he stated limited his mobility. Ingrained dietary habits. Motivation for weight loss good. Is to start WIN/OJT as security guard.
- Social Evaluation at Final-Not done.
- Current Welfare Duration-5 months.
- Welfare Support at Initial$237.00, at final - $0.00.
- Intervention-Weight reduction, exercise. Attended regularly, using universal gym in building daily 3 weeks (10 lb. weight loss) until placed on night shift. Resumed 3 months later. No net loss during intervention. (13 contacts)

- Work History/Status-2 jobs, dock worker, gas station attendant, 1 1/2 years. Final - Security guard ($4.32/hr.).
- Final Staff Evaluation-Intervention provided insights into obesity control. Referred to other program. Weight loss essential to long-term employment.

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- Male, age 45, lived alone. Left school after 9th grade to work.
- Past Health History-Asthma as child, fracture left foot - 1972, fainting episodes since 1974.
- Presenting Health Problem-Blackouts.
- Chief Physical/Psychological Findings-Epileptiform seizures -alcohol related, alcoholism, hypertension, dental caries. Beta score 83, hypochondriasis at initial 17, at final 26.
- Social Evaluation at Initial-Face red, severely blemished, teeth visibly bad. Mild mannered, slightly shakey. Stated blackouts (5 times/year) prevent employment. Ascribed onset to a fall. Job available upon rehabilitation. Socially isolated. Denied alcoholism.
- Social Evaluation at Final-not done.
- Current Welfare Duration-15 months.
- Welfare Support at Initial-$204.00, at final - $214.00.
- Intervention-Neurological work-up, liver studies, dental treatment, control of hypertension, control of alcohol intake. Cooperative. Stated he stopped drinking. (15 contacts)
- Work History/Status-Several moving jobs prior to 1963, not remembered. 4 jobs, cement worker, mover - 1963-75.
- Final Staff Evaluation-Motivation to work facilitated intervention success. Had not known relation between alcohol and seizures. Prognosis good if employment is obtained in near future.

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- Male, age 39, on Home Relief, lives alone. High school graduate.
- Past Health History-Auto accident as child - hospitalized with fractured vertebrae and nose injury, also laceration of knee. Long history of heavy smoking and nerves, chest pains - 8 months. Cysts on skin. Surgical treatment of tendonitis - right leg, hip, back . Hypertension.
- Presenting Health Problems- Emotional problems, leg problems.
- Chief Physical/Psychological Findings-Alcoholism, alcoholic hepatitis, drug abuse, anxiety depression, vertebrogenic pain syndrome, acne vulgaris, hyoertension, dental caries. Beta 97, hypochondriasis at initial 21, at final 19.
- Social Evaluation at Initial-Small, fragile appearing, bad complexion, nervous, trembling, upset, depressed. Social isolation, anxious when away from home - especially driving in traffic. Unresolved tensions regarding his homosexuality. Desired part-time work near home, but was applying for SSI.
- Social Evaluation at Final-No improvement. Needed intensive counseling and therapy for health problems.
- Current Welfare Duration-3 years.
- Welfare Support at Initial-$104.00, at final-$211.00.
- Intervention-Individual counseling, alcohol and drug counseling and detoxification. Treatment of acne and back. Responsive, but missed several appointments unavoidably. Denied drinking despite lab results. No improvement. Referral to psychiatric center for treatment at case closure. Was admitted as inpatient. (21 contacts)

- Work History/Status-3 jobs, clerk, assistant manager. Employed 10 years, worked last in 1974.
- Final Staff Evaluation-Poor prognosis unless he gets effective on-going counseling, detoxification.

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- Female, age 32, head of household, 2 children - ages 15, 7; left school at 16 to work. Completed 9th grade.
- Past Health History-Burns, strabismus- as a child, nearly blind in one eye. Also recurrent ear infections. Long-term allergic rhinitis, chest pains, and heart murmur, medically evaluated - 1971. Nerves - onset 1971.
- Presenting Health Problem-Anxiety depression.
- Chief Physical/Psychological Findings-Mild mental retardation, ambylopia, anxiety depression, allergic rhinitis, functional heart murmur. Beta score 65, hypochondriasis at initial 15, at final - not done.
- Social Evaluation at Initial-Congenial, direct, depressed affect. Social isolation, loneliness. Health concerns were fatigueability, poor vision and hearing, children's health problems and financial restrictions also stated as concerns. Wanted secretarial skills training.
- Social Evaluation at Final-Unreliable regarding appointments. Intellectual and performance scores indicate low potential for job skills training desired.
- Current Welfare Duration-15 years.
- Welfare Support at Initial-$99.00, at final $326.00 (changed residence, stopped working)
- Intervention-Counseling. Attendance erratic, showed for only 2 appointments. Advocacy with regard to toothache-she had been denied Medicaid. (7 contacts).
- Work History/Status-2 jobs - home aide, babysitting - 7 months in 1977.
- Final Staff Evaluation-Capable of working full time, ambylopia only limitation. Needed ongoing counseling.

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- Male, age 32, head of household, lived with wife and 5 children - ages 17, 10, 8, 8, 1. Graduated from high school in Puerto Rico.
- Past Health History-Traumatic loss of left eye as child, also laceration of right hand and tonsillectomy, inflamed right testicle - 3 years' duration, severe left ankle sprain - 1975, headaches, dizziness, loss of balance - 6 months.
- Presenting Health Problems-Constant eye problems.
- Chief Physical/Psychological Findings-Anxiety, depression, chronic epididymitis, blindness - left eye. Beta score - not done. Hypochondriasis at initial 22, at final 14.
- Social Evaluation at Initial-Spoke only Spanish, with interpreter. Appropriate dress, behavior. Glass eye. Frustrated by health problems continuing after consultations with specialists. Motivated to work. Not motivated to learn English.
- Social Evaluation at Final-language barrier unchanged. Has been seeking employment.
- Current Welfare Duration-2 years.
- Welfare Support at Initial-$352.00, at final - $538.00.
- Intervention-Referral for evaluation of epididymitis. "Small tender nodule, not requiring treatment." Evaluation of headaches: x-rays, scan and EEG, were normal. Treated with Fiorinal. Referred to Spanish Action League for psychological and job counseling. Referred for upper G.I. series for epigastric pain. (11 contacts)

- Work History/Status-Supervised painters for 4 years in Puerto Rico. 6 weeks employment in U.S. as laundry worker - 1975.
- Final Staff Evaluation-Employability limited by eyesight and language barrier. Spanish Action League an appropriate resource for counseling re: coping with health problems and gaining employment.

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- Male, age 32, lives with wife and 4 children - ages 7, 4, 2, 1. Stated he graduated from college and had Master's Degree. Had training as a chef.
- Past Health History-Injury - left hand with residual numbness as a child. Fractured skull - 1965, hospitalized for alcoholism - 1967-68, recurrent laryngitis, onset 1968.
- Presenting Health Problems-Alcohol abuse.
- Chief Physical/Psychological Findings-Alcoholism, hyperventilation syndrome, periodontal disease, dental caries. Beta score 70, hypochondriasis at initial 17, at final 12.
- Social Evaluation at Initial-Appearance disheveled, missing teeth evident, excited, slurred speech, seemed intoxicated. Stated he reacts with violence to constraints of his will. Uses alcohol to dispel nightmares and visual hallucination related to Vietnamese War. Stated education very dubious. Has fathered many children. Amenable to psychological and vocational rehabilitation.
- Social Evaluation at Final-Responded well. Better self-image, self-control. Alcoholism sporadic, produced by frustration, boredom. Needed job.
- Current Welfare Duration-1 year.
- Welfare Support at Initial-$204.00, at final $214.00.
- Intervention-Alcoholism counseling; Client instigated this himself. Dental treatment- Response good. Psychological counseling - good response. Health education - good response. (19 contacts)
- Work History/Status-5 jobs. Army, chef,"therapist", teacher. Worked 9 years, last in 1976. CHRP referral to CETA Job Training.
- Final Staff Evaluation-On-going alcohol counseling recommended. Prognosis good if employed or in job training. CHRP rehab very effective in this case.

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APPENDIX E

SURVEYS

CHRP SURVEY OF REGIONAL WIN DIRECTORS

Data from the telephone survey of nine Regional WIN Directors are presented in this Appendix as follows:

a) Question asked
b) Tabulation of responses
c) Quotations from interviews

(In cases where the respondents did not elaborate on their answer, no quotations were included.)

Questionnaire and Responses

1. DO YOU SEE A NEED FOR A UNIFORM HEALTH EVALUATION OF CLIENTS WHO CLAIM A HEALTH PROBLEM AS A DETERRENT TO EMPLOYMENT?

Responses:

4 - Yes
4 - Qualified
1 - No

Saw a need for uniform health evaluations

"I don't think our medical assessment of physical or mental problems is adequate either as done by the Income Maintenance staff initially where there may be some question as to the exemption or later when there's an appraisal of the individual to determine their job readiness. I think any of the physical examinations tend to be fairly superficial and mainly limited to identification of any physical limitations and not really the type of indepth [evaluation] where there is evidence of a physical and mental condition -- the kind of indepth assessment, for example, that is done in vocational rehab."

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"One thing that has really bothered me is that very problem. [In one state], they said it was so difficult to get a well-rounded health evaluation. They had doctors who didn't understand the WIN program. They had trouble getting appointments. They had long waits. They got doctors who always said that anybody could work. Everybody can work if the situation is right, whether it's sheltered workshop, or you had all sorts of supporting services going from morning to night. Even the most severely handicapped can work but there's such a range in there - what that means, 'Can work'. In the context of WIN, it would normally mean leaving the home and going out to a competitive job situation. I said to this state coordinator, 'We'll get a doctor and educate him on WIN and then maybe you can [get uniform health evaluations]', but there's not much freedom on how they get these doctors. They have to take them from wherever the state or somebody tells them they can take them. The same is true in the psychiatric situation. It's really hard for the social workers and employment service workers in the field to get the realistic kinds of judgments they need, in terms of what is expected of these people when they go out to work."

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Qualified responses re: uniform health evaluation

"Well, I don't think that would be very practicable in areas that had a much smaller WIN population. It might be practical in a larger metropolitan area where there are a large number of exemption requests due to claimed medical problems."

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"From what I understand, it is unsatisfactory and I'm not sure that a uniform procedure would satisfy the problem. The kind of experience I'm familiar with is where there's a lot of shuffling between the Income Maintenance Unit and the Employment Service in terms of who's going to do what, when. For instance, a client is considered as requiring to register in the WIN program and she's referred to the Employment Service and the Employment Service sends the client back saying this person should be exempted from the program, she is not capable. Her physical condition prevents her from employment. We have no suitable guidelines in that area. I think that's as much a problem as anything else. I'm not sure, if that can be handled on a uniform basis."

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"Oh, it would be very nice if we had an automatic go and no-go gauge but I think it would be awfully difficult to establish a standard one, because you would maybe be talking about a mole hill situation and have a mountain standard evaluation process. So, it would be pretty difficult. Now, if you had something rather basic and elemental to cover some pretty common re-occurring discrepancies or incapacities it might be good on that but you know that's almost like asking how long's a piece of string."

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"The only determination they're asked to make is based on the present level of the client's skills, knowledge and ability. Are they employable in the sense that they have the physical and emotional capacity to conduct themselves in a job. That's a pretty broad rule to go by. It's not more refined than that, and I don't know if it would be appropriate to exact a more rigid standard just specifically for WIN. The case is -- are they employable? Can you work? Are you able to work? [Evaluations] are administered by the individual welfare projects. There are state standards. In addition to that there may be, in the case of county administered welfare programs, county standards. I'm not saying that an individual who was found eligible for the program in county A would be disqualified in county B or vice versa. I'm saying the potential exists that with the lack of uniform standards for determining eligibility or employability, that a variance could occur and frequently does in the administration of the program and the determination of the eligibility requirements."

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Did not favor uniform health evaluation

"I don't see how it could be uniform. As I said on the survey before, 'No'. I was one of those that felt that the present method was unsatisfactory but I would think a rigid procedure would be even a greater impediment than the hodge podge we have at the moment."

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1a. IF YOU DO NOT FAVOR UNIFORM HEALTH EVALUATIONS, WHAT ARE YOUR REASONS?

Response: 1

"Because I don't think that you'd ever get the medical profession to carry out their duties with that degree of uniformity."

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1b. IF YOU DO SEE A NEED FOR UNIFORM HEALTH EVALUATIONS, WOULD YOU FAVOR HEALTH EVALUATIONS BY PHYSICIANS WHO ARE TRAINED AND/OR EXPERIENCED IN EMPLOYMENT-RELATED HEALTH EVALUATIONS?

Responses: 8 - Yes, both trained and experienced physicians.

Favored health evaluations by trained and experienced physicians

"I think that's really very important. If a physician doesn't understand all the social implications of what's going on, the social and economic implications that the family are facing or the mother is facing, why, he might say - 'Sure, she can work.' I think that if you had the judgment of competent professional social workers and maybe the employment service, some prominent people not necessarily doctors who look at the whole circle of the situation of employment and health, that you might get a better judgment than if you just relied on say two doctors - one a psychiatrist and one a medical man. The perspective would be different."

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"It certainly would not hurt, because we have to rely on the medical profession time after time and frequently they have no concept at all of physical demands of certain types of jobs. You send someone to a doctor to get an assessment of his physical capacities and you get back a report from a doctor [who is] asked to make opinions in areas that he has very limited information or knowledge about. Certainly there is room for them to have some training or knowledge or background in [employment-related health evaluations.]"

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"Well, it would be better if it could be done only by those [who are both trained and experienced] but we might run into a problem because of the clients' desire to use their own physicians. It would be better if we could because so many times we do not get a health evaluation which is most pertinent to our needs."

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1b. (continued)

"Yes, I think on the whole that physicians have a very poor understanding of what the WIN program and AFDC are all about when it comes to determining disability. I think often physicians' own attitudes get in the way of providing us correct information."

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"Yes, I think the doctors that we use need some training in what our needs are rather than the old 'feel 'em and see if they're warm, and yes, they're warm so we'll let them go on about their business.' [They need] some kind of training and orientation to help them know what our needs are because many times this is just another form to fill out."

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2. SHOULD SUCH PHYSICIANS BE ORIENTED TO THE WIN PROGRAM BY WIN PERSONNEL?

Responses: 7 - Yes
1 - Yes, jointly with VR
1 - Qualified

Saw a need for orientation of physicians to WIN program

"I think that would be ideal. I don't think that the bureaucracy has that control over the medical profession so I really don't see the question as having much of an opportunity to change something that needs to be changed."

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"I think that some type of orientation should be given to the physician if nothing more than a form letter that explains the purpose of the WIN program, the fact that this person is expected to register for employment and what you're really expecting of a physician."

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"I think you'll find in this region by and large that they've had no choice. [It has been carried out] on a one-to-one basis for the most part, primarily in the larger places because although a client does have the right to get his own physician frequently we can recommend one that we've had some contact with that will give us some special help of getting them in at a certain time, or will make hours available to handle them when we couldn't get them in to just anybody."

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"I think there should be some orientation to them from the world of work. I think what we could do which would really help would be if we could set up a joint thing with Vocational Rehabilitation and WIN because we're really looking for the same type of thing. Vocational Rehabilitation is looking for a physical examination of a person to determine: 1. Should they be rehabilitated in some kind of work and if so, how strenuous should it be and that's exactly what we're looking for."

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Qualified response re: WIN orientation of physicians

"The only determination they're asked to make is based on the present level of the client's skills, knowledge and ability. Are they employable in the sense that they have the physical and emotional capacity to conduct themselves in a job. That's a pretty broad rule to go by. It's not more refined than that, and I don't know if it would be appropriate to exact a more rigid standard just specifically for WIN. The case is -- are they employable? Can you work? Are you able to work?"

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3. DO YOU SEE A NEED FOR THE SAME PHYSICIANS TO DO A FOLLOW-UP EXAMINATION AFTER REHABILITATION?

Responses: 5 - Yes
1 - Yes, qualified
1 - No
2 - not asked

Same physician to perform follow-up

"If requested, yes, I think it will be an appropriate part of an employability plan that if you had the required supportive services or therapeutic sessions with the physicians that you'd have to have a determination of availability for work as a follow-up to determine: a) the adequacy of the treatment that was rendered and b) as an indication to the job development -- this person is employable and should either be put into training or into work."

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"Well, that would certainly provide the continuity. I would think it would be the best to do that but it might not be practical."

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Not necessary for same physician to perform follow-up

"Oh, I'm not sure that would be necessary. It might be desirable but I'm not sure that it's that necessary because your medical profession is pretty well prepared and pretty competent and for the most part what one would do would be pretty much in line with what another would do. I don't think we would want to make it so hidebound that we wouldn't have flexibility to go to a competent doctor when the need arose."

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4. SHOULD STANDARDIZED HEALTH EVALUATIONS BE DONE AT INCOME MAINTENANCE (IM - INTAKE) OR AT WIN REGISTRATION?

Responses: 4 - At Income Maintenance
4 - Both Income Maintenance and WIN
1 - Not asked

4. (continued)

Favored health evaluations at Income Maintenance level

"The income maintenance person is responsible for applying the exemption criteria and one of the exemption criteria is disability. I really don't see the need for a person to be referred for registration if in fact they have some disability."

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"I don't see that it's necessary for WIN registration to get into that because we would then have a hassle because the rules and regulations now say that the determination of whether the person is to be registered or not still rests with Income Maintenance. If Income Maintenance got an individual and said the person should be registered for WIN and sent him over to WIN for registration and WIN sent him through this evaluation and they came back and said - 'Well, our doctor said he shouldn't be registered.' - then we've got a hassle which should not exist. So, I would just as soon continue the present route. We would send him back to Income Maintenance for a special check on him and that way, if the doctor came back and said he should be registered or he shouldn't be registered, then we've got our story straight. There wouldn't be any real hassle between the two agencies."

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Favored health evaluations at both Income Maintenance and WIN

"That question is another example of what I would consider inflexibility. In my opinion it has to be done in both and the way the program is at the moment, it can be done in both the IMU and the SAU level. In other words, there are certain people with disabilities that are going to escape the medical IMU screening. They're going to get into the WIN system. They can then be picked up by the SAU. If there was a policy change that limited medical to one or the other, then we would miss people and this would be an example of not meeting the degree of consumer need that would otherwise be met."

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"It probably would reduce the amount of run-around that the client is subjected to if both were involved in it. If the Income Maintenance staff feel that it's a problem, then they can refer the person to a physician who would complete the evaluation and then based on that evaluation, they would either exempt a person or refer them on to the Employment Service. Now, if they refer someone to the Employment Service and they feel that this person is exempt, then they should be able to have the facilities without sending them back through the system because it just creates a lot of friction between the two agencies, just because there's no procedure for it."

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4. (continued) (Favored both at IM and WIN)

"At the present time, it's done at both places because your income maintenance can be working on application for grant at the same time that they send the client over for registration and something can come up at the point of registration that was overlooked by the IMU. I would be inclined to think that you still ought to keep both check points because certainly if one didn't pick it up, you've got a better opportunity to pick them up at another. The IM people are responsible for requesting a medical assessment if it's more than just a matter of visual assessment of an incapacity. Frequently there is an exchange of requests and information between the WIN sponsor and the IMU worker and I think that that should be continued because the IMU person may be speaking in generalities and the generalities may be that there were a lot of different kinds of jobs that that client could do, but yet when you get to the WIN sponsor, they're most specifically concerned with the kinds of jobs that are available in that area and what the demands of the employers of that area are and therefore, it's a kind of backup to the general [evaluation]."

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5. SHOULD THE PHYSICIANS WHO WOULD PERFORM UNIFORM HEALTH EVALUATIONS BE LOCATED IN AN AMBULATORY PRIMARY CARE SYSTEM (SUCH AS A FAMILY MEDICINE CLINIC), COLLOCATED WITHIN DSS, COLLOCATED WITHIN DOL (EMPLOYMENT SERVICE), IN A HEALTH SCREENING SECTION OF THE HEALTH DEPARTMENT OR SOME OTHER PLACE?

Responses: Varied

Saw a need for flexible, accessible location for health evaluations

"We have tried [clinics and health departments] in the past in our disability assistance program and that does present some consumer problems including transportation in getting to a more limited resource of physicians. So, you know, it's a case of trade offs. Losing some and winning some. I think that to meet consumer need, we need to display more flexibility rather than less and I'm really personally very fearful of schemes that reduce flexibility for consumers. It's too hard as it is for consumers to get needs met through our system."

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"It's awfully nice if you have a public health center where they can be available and can be utilized there, that's fine. But alot of the places where we serve clients are where the clients reside. There's not necessarily such a space available to them. So, you would have to look a little closer to the environment where the WIN client especially resided. It would really depend on the whole city and situation, transportation and a whole lot of things."

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5. (continued) (Saw need for flexible, accessible location)

"[An ambulatory primary care unit] would be highly desirable if there were some mobility attached. This may be in the form of a mobile laboratory or a mobile health unit especially in the areas of remoteness from an active WIN project or in rural areas where transportation is a problem, if a mobile health unit could be available from a welfare department on a frequent periodic basis -- frequent enough so that they could make determinations that on such and such a date the individual would have a health screening as part of their general employment plan - say that within your section of a rural county. Unfortunately, those kinds of peripatetic situations are difficult to control and more difficult to plan on, especially where there is an employability plan being developed in connection with each WIN applicant."

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"I believe that the situation should be located as reasonably near the client, whatever vehicle or facility to me is unimportant, as long as it is accessible and convenient to the client. Therefore, the answer could be a number of answers to that. Wherever it is more convenient. Let me put it this way. Whichever facility is near, if it's the DSS that's more accessible to the client, I would say the DSS. If the employment service were more accessible to the client, then the employment service. If it's a collocated situation, I would op for the collocated situation. I think ideally the collocated situation would be a good one whenever possible or feasible."

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Health evaluations located in health departments

"County and city health departments could very easily [do this kind of screening] and in most cases, that's where a determination is made. If there's a question of the client's eligibility for a program, then a referral is made to a doctor who is on staff either in your county or city health departments and a volunteer who will make his time available for these kind of determinations or they will send the client to him for an evaluation in which the welfare department will pay for the visit, unless the client wishes to substitute their own doctor's information."

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Not practical to locate health evaluations in DSS or SES

"In most situations, at least within our region, there are only probably two or three metropolitan areas in which a full-time or even a part-time physician being collocated in either the Department of Welfare agency or the Employment Security agency would be justified. I don't think that that's a very pratical way of doing it. I think that there certainly could be some standardizations and medicals that might be performed by the public health department, for example, for any kind of agency that deals with employment. There are other agencies in which health examinations may be done to determine the person's employability. I think that physicians need to have an understanding of the relationship of the particular disability that a person claims and how that will effect their employability."

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5. (continued) (Not practical to locate health evaluations in DSS or SES)

"Oh, it could be an individual [physician]. It could be a family care center. That would be fine. I would not want to say put it in with either the welfare agency or the employment service agency for the simple reason that I think we would have trouble staffing it because the doctor would not get enough business just on this alone to keep him busy and we would either get a doctor that wasn't worth a damn and couldn't make a living otherwise or we would not be able to keep one. I'm just playing it the way it really is. If he had a practice and had an agreement with us that he would do these things for us, then he could go on with his practice and make all the money but then go ahead and do these. I think that would be a better, more satisfactory arrangement."

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6. ASSUMING THE FEDERAL WIN PROGRAM WOULD PROVIDE THE SALARY FOR A HEALTH COUNSELOR/HEALTH EDUCATOR, DO YOU SEE THE NEED FOR SUCH A PERSON IN LOCAL WIN PROGRAMS?

Responses: 6 - in larger programs
1 - in Income Maintenance only
1 - to serve health needs of general AFDC population
1 - favored community health resource development

Saw a need for a health counselor/health educator in larger WIN programs

"I think you're speaking now of the numbers of persons who have health problems and I think that where a history in certain areas indicate that there are a lot of health problems that relates to a WIN participant, I think in those area there should be a health counselor. If in a particular area you don't find that kind of situation, I think that there should be someone that could be called upon but not necessarily on a permanent basis or a full-time basis. It again depends on the history of health problems with the WIN participants in a particular geographical area."

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"I think that it would only be justified in a select number of projects [because of the number of clients]. I don't think it would be that worthwhile to have such a person to screen every client who would register for WIN because the majority of the clients who are registered do not have medical problems. I think in those cases where a person does have some kind of problem, the consultation with such a person as you mentioned would be beneficial."

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"Not unless it was in an extremely large project site because you wouldn't have a full-time job and that's such a specialized area, that it would be a waste of money and training to have very many of those around because if you don't have a caseload, you know, you'd blow a very good person's capabilities, and in addition to that, you could be very frustrating to that kind of a trained technician if he's not being utilized."

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6. (continued) (Need in larger WIN programs)

"I think he could be useful. Whether we could get sufficient value out of such a person - in other words whether there would be a large enough number of cases to warrant such a person or not I can't answer. I would seem to think we might not, partly because we don't have that many people that are registered with WIN that have health problems and partly the fact that the WIN agency when they find somebody with one of these problems there's a tendency to just drop him and go on with somebody who is more physically able and more willing to work."

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"Yes, I think that there could be a place for that kind of person, very definitely. I would think that from a feasibility or cost effectiveness point of view, probably only agencies say in the larger states or urban areas could probably afford something like that because they'd have the caseload. I think in our region, for example, most of it wouldn't be able to employ a person. Now, if there were health educators in either mental health centers throughout the state or somewhere where that kind of service could be purchased or provided for individuals who might otherwise be eligible either under Title XIX or Title XX or WIN if WIN resources were available. Then, I think working out some kind of an agreement with these mental health centers wherever they might be to purchase services would be a good idea. We might be able, then to move some of these people who let's say more chronic cases, more long-term AFDC recipients into the labor market."

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"There would be [a need] where there's cases that arise but I don't know about the frequency of the need. If you're speaking of a health counselor or someone [who could help in] situations relevant to the client's employability--something that requires health maintenance, if you broaden the scope of the role of the health counselor, the need would be greater."

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Did not see a need for health educator in WIN

"Not within WIN because you're not asking within the right area. You should ask in the Income Maintenance unit attached to the county welfare department. They determine eligibility for health services, direct or support services, coordinated within the welfare agency itself. If the determination is made on a welfare client's eligibility for work, and the welfare agency decides the person can't work then they're not eligible for WIN. There's no point in sending them to WIN to make the determination for eligibility first because available to the county welfare office are a vast range of other services. When I say vast, I mean vocational rehabilitation and other kinds of supportive services that the clients could take advantage of and yet not be included in the WIN program."

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6. (continued)

Saw a need for health educator for general AFDC population

"The thing that I'm not clear about is where the WIN population would be different from the general AFDC population and Medicaid and all that. The WIN population represents [in one state] at least about half of the total AFDC population. But that could vary a lot in states. But how are the medical health needs of the AFDC population as a whole being met not just the WIN population? Also WIN is such an underfunded program. WIN is not funded to even follow-up on the mandatory registrants. Anywhere from 50 to 75% of the mandatory WIN registrants who have to register because it's the law, may be getting minimal attention because there's not enough money in the program. So, if you were looking at an optimal approach, that's one thing but when you talk about WIN, you're really talking about sort of a segment and it seems to me the question is how are all these health needs - needs of teenagers, needs of children, pregnant mothers and all that - how's that handled for the total population and I really don't know."

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Favored community health resource development

"Generally, I oppose that concept. I feel that a major job we have is to help our consumers to avail themselves of existing community resources and if the WIN system or other categorical kinds of programs developed their own house or ship, it's complete, then this is really not helping WIN citizens to use available community resources, and they also get earmarked. So, I generally feel that we should do more work within the area of resource development of existing resources or new resources in the community rather than singling out a group of people and further isolating them from the main stream. I think it's very unfortunate when we isolate people from the main stream. I think we need to be very careful in our program planning not to do that. I would say over a third of the people we have in our caseload have medical problems. I also feel that we're not really meeting the challenge and that a lot of work needs to be done in this area. So, I don't think that there's any argument as to what the need is. I think that there is some honest difference of opinion between people on the way they carry it out and to reiterate, I believe that we need to help people get into the main stream as much as possible. This could be brought about by community organization."

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7. SHOULD THE HEALTH COUNSELOR BE LOCATED IN INCOME MAINTENANCE IN THE WELFARE AGENCY, IN WIN/SAU, IN WIN/DOL, IN A HEALTH CARE UNIT OR OTHER LOCATION?

Responses: 5 - Income Maintenance
3 - WIN
1 - Not asked

7. (continued)

Health Counselor located in Income Maintenance

"I'm not sure that we shouldn't retain the kind of approach we have now of Income Maintenance being the first ones to detect signals of need for and then having a backup to the WIN operation. I guess that if you were going to have them in a place to justify them, that it would be better to have them in the welfare system at the intake point."

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"I think to fragmentize WIN away from the total AFDC is a mistake. Of course he is as total as a taxpayer or as a manager. This WIN program is funded to so small an extent and need already. So when you talk about all these WIN units, you're thinking several hundred or thousands in all the states. I'm wondering, if I consider health care and prevention and education so important, it ought to be assured right at the beginning of this whole thing right in the AFDC office. I mean it seems to me so. Now, that doesn't mean that the other might not be feasible."

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"I would suggest that if you are looking to establish a particular position that it would be under the auspices of the county welfare department and not be allied directly with the WIN program. It would be difficult to support such a position within the structure of the WIN sponsor which is traditionally the employment service. You would have better luck establishing the need for and provide continuity to the position of a health service coordinator within a local project, if the person were affiliated with the Department of Public Welfare. This does not mean the individual could not be on site within the WIN project on a certain number of days of the week but they should be identified as a welfare employee and that their services should be bridged in terms of initial medical determinations and any follow through on rehab services that have been offered plus any additional on-going either prosthetic or additional medical services the WIN client might require."

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"I would put this person, if not in the Income Maintenance, certainly in the SAU. If they were in Income Maintenance, they could perform a similar service to non-WIN clients, if there was not sufficient work for them to do with just WIN clients. Whereas if you've got him over in the ES unit, they would be restricted to WIN people so there would be nobody else to get to them."

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"There are several points within the program where a person might relate or claim some kind of medical problem. This could be done at the initial point of being screened for the WIN program and this is where the Income Maintenance worker wouldn't see them. At that point, generally there is no social service worker. And generally what happens if the person claims some kind of illness or disability whether they claim it's temporary or permanent, the Income Maintenance worker makes a referral or is supposed to make a referral to a physician or a health agency to verify the perported

7. (continued) (Health counselor located in Income Maintenance)

disability. It could be either to have a health counselor or to see to it that the Income Maintenance workers are trained to do that and perform that function. And again I don't think that most local welfare agencies would have a frequent enough need to justify such an individual. Many of the larger welfare agencies in the large metropolitan areas are decentralized in that their application process for public assistance is done at 15 to 20 centers throughout the metropolitan area. So, ideally to follow your line of thinking, you would have to have one of these people available at each of these centers to go along with, at least the agency's philosophy of decentralization and having all services available within a complex where the person is applying. Again a person such as this might be of value if they were a part of the agency's staff development unit and that this was their area of expertise and they could train social workers and Income Maintenance workers to be better health screeners."

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Health counselor located in WIN

"I think the most appropriate location would be the SAU - not social services because I see this as a supporting service and by definition is the primary responsibility of the SAU. I think in the move toward integration of some of the program activities that you look at WIN as a totality and it really doesn't make too much difference which agencies actually wind up with the major responsibility. But right now, given the reality of regulatory arrangement, I think SAU would be the appropriate place for it."

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"Collocated, with the WIN program."

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"I would say that probably the most strategic point would be as one of the partners to the appraisal process because there would be many who would be referred on over to employment service. If this individual were located with IMU, maybe ES would have a question about it even though this person screened them and if part of the sensitivity is related to employability, there would be more opportunity for communication. So, I'd probably feel it would be more appropriate there with the social service worker and the employment counselor."

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8. SHOULD THE HEALTH COUNSELOR/HEALTH EDUCATOR BE PLACED AT THE SAME STAFF LEVEL AS THE EMPLOYMENT COUNSELOR, HIGHER THAN THE EMPLOYMENT COUNSELOR OR LOWER THAN THE EMPLOYMENT COUNSELOR?

Responses: 3 - Same staff level
1 - Higher than employment counselor
5 - No answer

8. (continued)

Health educator at same staff level as employment counselor

"I think it would be a peer relationship. I would see it similar to some of the responsibilities of a rehabilitation counselor. It would certainly be a professional position given whatever civil service stature it would need in order to have a peer role with the other members of the team."

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"I'd say this person definitely is a part of the team and probably on an equal footing. As it stands now, we consider this process as a three part process ultimately involving in a contract between the three parties - the SAU, the employment counselor and the client."

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Health educator at same or higher staff level than counselor

"If not the level of employment counselor, then Deputy WIN Director, something like that at a project level. They ought to carry a little weight."

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9. WE ARE IN THE PROCESS OF MAKING RECOMMENDATIONS WITH REGARD TO DEMONSTRATION PROJECTS WHICH WOULD INCORPORATE HEALTH COUNSELORS INTO THE WIN SYSTEM. WOULD YOU BE WILLING TO HAVE THIS AS A DEMONSTRATION PROJECT IN YOUR REGION?

Responses: 7 - Yes
1 - Declined to answer
1 - Felt appropriate in Income Maintenance.

Indicated interest in a demonstration model

"I'm particularly concerned about innovative approaches to enhance the client's productivity and definitely in a health situation which is very severe. As you know, it's one of the great obstacles to gaining employment so we would be interested in such a demonstration project through the national office or through the state. I would like to see one such program as a demonstration project and again I think in terms of a congested area. I would like to see this in collaberation with the state. The state can either do it or hire a consultant to set it up as they have done with other demonstration projects. Then the state would monitor the program. It would be feed back to the regional office on a periodic basis in terms of progress, problems and what have you. I can see the regional office involved in it in terms of our monitoring, the progress of the program and at the end of the year we could have a full progress report in terms of did the program work as compared to a control group and what are the problems and should we continue with it. I think we need that year's experience to iron out the bugs and to evaluate such a situation."

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9. (continued) (Interest in a demonstration model)

"I'm glad to see there is interest in this area because it tends to recognize the total dimension of the person which basically our current staff are not equipped to deal with or to be alert to those needs. I'd be in favor to see what we could do with it. I would think that you could get down into areas as fine-eyed as nutritional needs which have a bearing on a person, whether they have any energy or not would of course affect the employability, motivation and so forth. It would bolster the concept of the total person in terms of meeting their overall needs if a health counselor were introduced into that employability appraisal situation. I would say that it probably would be a good thing to be tested in some large urban areas and we would be willing to solicit for it. Initially, what we'd have to do is provide some kind of quick and dirty survey to see if we have any high needs and any particular locale that we have data to support it. If we find that we have a large number of exemptions on the basis of incapacity, for instance, which we do not record and are not required to be reported now, if we were able to identify that just through some cursery surveys, then of course, we would want to target in on those areas. We have some old data that was required as a reporting item back several years ago. I think we only dropped that about two years ago, so we could go back and look at our old data and probably identify the frequency of this. In addition, there, of course, would be manifold needs within the children of these registrants which may or may not surface during the appraisal interview but which could be explored if a health counselor were on the scene and therefore pick up medical needs, health needs, of children who are not being screened adequately by the early periodic screening that goes on under that program. So, there's possible beneficial spin off in that direction which again if you've got a child with a major health problem, that could be a deterrent to employment. That, of course, should be picked up but many of our registrants as you know or probably know are volunteers in the program, so unless this is brought out as a problem that would prevent employment, it may go unrecognized."

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"This could be extremely useful [especially with regard to] this unassigned recipient. An awfully lot of them are probably more or less unemployable otherwise the WIN office would be working with them on either training or placement so you have to assume that there's a lot of unemployability there and the other assumption you have to make is a lot of health problems. So if you really wanted to get to that group, then a health worker who is evaluating all of these WIN registrants might prove to be extremely useful. I guess it depends on how comprehensively one will look at the total AFDC population. If you want to look at the WIN segment, that's certainly important. Of course, even while people are working, they get health problems. A lot of them are working at entry level jobs and a lot of them are underemployed and in an ideal situation, you could have a person really in there working with them, a person who could go in the homes and work with the families."

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9. (continued) (Interest in a demonstration model)

"There are only about three places in my region that I would even think that you might be able bearly to justify that because of the numbers we're talking about again. I don't think that we'd have caseloads large enough in other areas to justify that kind of thing. Now it might be possible that you could work out such an approach dealing with both CETA and WIN clients because there's a proposal now for the Welfare Reform Act which may incorporate the CETA program to furnish the jobs to those people who need them under welfare reform so it would be very logical to consider such a place or position perhaps if you had any kind of demonstration or trial program in approach to welfare reform because if you're dealing with those two segments, that would be a pretty good size population and that would not be only welfare clients, it would be all types of clients."

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"I'd like to see it tried as a pilot project someplace and be worked out. I would not see one in every local project. It might work out that way. I'm not sure how many of them would be that usable. I would say some of your major city projects in all probability could. I mean there would be enough work for them to do to keep them busy."

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"Several years ago, there was work that was done on a written questionnaire that the clients would fill out which was a medical questionnaire and I would like to see more work done in that area. Again, I feel that we're missing alot of health needs amongst our clients and that to be as successful as we'd like to be, we need to do alot more in the medical area."

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"I have a strong interest in this, I think it's one in WIN that we've tended to neglect. I think when you are given an emphasis to direct your attention mainly to the job-ready, individuals with health problems do fall down the priority list. You either look to other programs to try to get the services for these people that you can whether it be voc rehab or Title XX or Title XIX or whatever it might be or you try to promote it within your own and so far that line hasn't been too fruitful, mainly because of budgetary constraints, not a lack of interest. We're caught in the same kind of situation that many other federal programs are -- there are just so many dollars available and everybody competes for them and this kind of a program doesn't quite get some of the visibility that general health, for example, health insurance as a total program is getting today. Most state operators will place goals on their staff that will almost require them to look only at those who have minimal service needs, someone who needs a pair of glasses or maybe some kind of dental treatment of some kind, maybe dentures or not too much in the way of cosmetic dental treatment. Persons who have hernias or back problems, or neurological conditions, like epilepsy or cerebial palsy or things like that, would be rehab eligible. You will find a number of AFDC recipients that rehab used to accept in the way of behavorial or social incapacitating disabilities, but no longer are. You'll find alot of these on welfare and these are the type that have very difficult problems with either accepting employment or retaining employment once accepted and WIN just doesn't have the resources to provide the kind of counseling or psychological assistance that these people need to change their behavorial pattern or whatever it might be."

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REGION ____

CHRP SURVEY OF WIN DIRECTORS

NAME ____________________

DATE ____________________

AGENCY ____________________

TIME ____________________

TITLE ____________________

A. More than half of the respondents returning the original questionnaire replied that present methods of medical evaluations of clients who claim a health problem as a deterrent to employment were unsatisfactory.

1. Do you see a need for a uniform health evaluation of clients who claim a health problem as a deterrent to employment assuming that the health evaluation would be paid for by Title XIX funds?

Yes ____ No ____

a. If you do not favor uniform health evaluations, what are your reasons?

b. If you do see a need for uniform health evaluations, would you favor health evaluations only by physicians who are trained and/or experienced in employment - related health evaluations?

Trained ____ Experienced ____ Both ____ Neither ____ (Why?)

2. Should these health evaluations be done at Income Maintenance (IM - intake) or at WIN registration?

3. Should the physicians who would perform such uniform health evaluations be located

____ In an ambulatory primary care system (such as a family medicine clinic)
____ Collocated within DSS
____ Collocated within DOL (Employment Service)
____ In a health screening section of the Health Department
____ Other: Please specify -

4. Should such physicians be oriented to the WIN program by WIN personnel?

5. Do you see a need for the same physicians to do a follow up after rehabilitation? Why/why not?

B. None of the States or Regional Directors who returned the original WIN questionnaire currently had a health counselor/health educator as a part of the WIN program. A health counselor/health educator would provide a number of services with regard both to the initial health evaluation and to health rehabilitation.

1. Assuming the Federal WIN program would provide the salary for a health counselor/ health educator, do you see the need for such a person in local WIN programs?

Yes ____ No ____

2. What should be the duties of the health counselor/health educator?

____ Preliminary health interview
____ Maintenance of health related records
____ Referrals including follow-up to other health and rehabilitation agencies (such as weight control clinics, psychological, alcohol, drug counseling)
____ Client advocacy with health agencies
____ Health education and counseling
____ Laison with WIN counselors in SAU and DOL

3. Should the health counselor be located

____ In Income Maintenance in the welfare agency
____ In WIN/SAU
____ In WIN/DOL
____ In a health care unit (Health Department, Family Medicine Clinics, etc.)
____ Or other location - Specify:

4. Would introducing such a health counselor/health educator into the WIN system be

____ Very feasible
____ Somewhat feasible
____ Not feasible / Why?

5. Should the health counselor/health educator be placed at the

____ Same staff level as the employment counselor
____ Higher than the employment counselor
____ Lower than employment counselor

C: We are in the process of making recommendations with regard to demonstration projects which would incorporate health counselors into the WIN system.

1. Would you be willing to have this as a demonstration project in your Region/State?

Yes ____ No ____

If yes, where?

Department of Social Services
New York State Employment Service
CETA

CHRP AGENCY QUESTIONNAIRE

Name ____________________

Date ____________________ Agency ____________________

Time ____________________ Title ____________________

I want to talk with you about the Cornell Health Project and your evaluation of it. Basically, I am interested in three areas:

1) the current system of medical evaluations and rehabilitation of clients who claim a health problem as a deterrent to employment
2) the Cornell Health Project medical evaluations and rehabilitation
3) your opinion about a future model for medical evaluations and rehabilitation that would be optimal as well as administratively feasible.

I have a series of questions to try to get at these aspects of the system--

1. What is your opinion about the present methods (process/format) used by DSS-IM (Income Maintenance) to make medical evaluations of clients who claim a health problem as a deterrent to employment.

Do you believe they are satisfactory both with regard to the determination of --

1) incapacity? Yes ____ No ____
2) illness (temporary exemption)? = Yes ____ No ____

Why/why not?

2. (For ES only) Does the Employment Service do medical evaluations (screening) of DSS clients who claim a health problem as a deterrent to employment? Yes ____ No ____
If so, in what situations or for which clients?
What procedure do you follow?
Do you communicate your determination to the DSS -- IM unit?

3. What is your opinion about the medical evaluations (determinations) provided by the Cornell Health Project for your clients who claim health problems as a deterrent to employment? Do you believe that their methods have been satisfactory both with respect to the determination of

1) Incapacity? Yes ____ No ____
2) the determination of illness (temporary exemption)? Yes ____ No ____

Why/why not?

4. In comparing the two (three) methods of medical evaluations (IM, CHRP, ES), what advantages and disadvantages for screening clients for employment do you see?

5. There has been some discussion about a standardized health evaluation procedure, particularly in areas where there is a WIN program.
If a standardized health evaluation procedure were developed, which of the following systems would you favor? (Read list before recording choice)

Collocation of a health unit within DSS _____
Contractual arrangements with local family medicine clinics _____
Appointment of approved physicians in the area to carry out health evaluations _____
Contractual arrangement with the U.S. Public Health Service or county PH facilities _____
Other:

Why/why not?

6. Do you believe that job-readiness rehabilitation services should be provided by DSS -- such as (Read list before recording answers)

_____ Medical referrals
_____ Referrals to psychological counseling
_____ Health education
_____ Health guidance and counseling
_____ Nutrition/budget counseling
Other:

Why/why not?

7. Cornell Health Project has been providing rehabilitation services to DSS and other clients during the past two years. What is your evaluation of the rehabilitation services they provided? Would you say: excellent, good, poor, or no opinion?

	Excellent	Good	Poor	No opinion
Medical referrals	_____	_____	_____	_____
Psychological counseling	_____	_____	_____	_____
Health education	_____	_____	_____	_____
Health guidance and counseling	_____	_____	_____	_____
Weight control	_____	_____	_____	_____
Personal hygiene	_____	_____	_____	_____
Nutrition education	_____	_____	_____	_____
Personal staff contacts	_____	_____	_____	_____
Other:				

8. What have been the advantages and disadvantages of having Cornell Health Project provide rehabilitation services for DSS and other clients?

9. Do you think that having clients exempted from bi-weekly reporting to the employment service while they were in the Cornell Health Program has been a good idea or not? Yes ____ No ____
Why/why not?

10. If a client is found to have health problems and the examining M.D. determines that treatment will not interfere with employment and are remedial within 90 days, which of the following would you prefer:
1) that employment and/or training be concurrent with treatment? ____ or
2) that treatment be completed before employment or training? ____
Why/why not?

11. What priority for employment would you give to a DSS client who has had a poor work history due to medical problems? Would you say --
a) give a high priority ____ b) treat like anyone else ____
c) give low priority ____
Why?

12. What priority for employment would you give to a Cornell Health client who has had a poor work history due to medical problems? Would you say --
a) give a high priority ____ b) treat like anyone else ____
c) give low priority ____
Why?

13. Has the health intervention by the Cornell Health Project increased the employability and job holding capacity of DSS clients who were part of the program?
Yes ____ No ____
Why/why not?

14. What would be the advantages and/or disadvantages of having a health counselor to work with DSS clients on medical rehabilitation for employment?

15. We are interested in what your idea would be for an ideal model for health screening and rehabilitation with the DSS/Medical/Employment service system. Would you work with this schemata and diagram your model?
(MODEL)

16. How administratively feasible would this be?

17. Under whose jurisdiction should the Health Counselor be?

18. Do you have any other comments on either the Cornell Health Program or the model for a future system?

CHRP CLIENT EVALUATION Date__________ #_________

I'd like to ask you some questions about the help you got from CHRP.

1. Did you have a problem with your nerves? . . . . Yes___ No___ (1)
   If yes, did CHRP help you get control of your nerves?. Yes___ No___

2. Did you need to lose weight? . . . . Yes___ No___ (2)
   If yes, did CHRP help you to lose weight?. . . . . . . Yes___ No___

3. Did you need to gain weight? . . . . Yes___ No___ (3)
   If yes, did CHRP help you to gain weight?. . . . . . . Yes___ No___

4. Did you need help in planning meals? . . . . Yes___ No___ (4)
   If yes, did CHRP help you to plan your meals better? . Yes___ No___

5. Did you need to get your teeth fixed?. . . . . Yes___ No___ (5)
   If yes, did CHRP help you get to a dentist?. . . . . . Yes___ No___

6. Did you need to get a regular family doctor? . . . . . Yes___ No___ (6)
   If yes, did CHRP help you to get a regular doctor? . . Yes___ No___

7. Did you get in the habit of regular exercise?. . . . . Yes___ No___ (7)
   If yes, did CHRP help you learn to exercise? . . . . . Yes___ No___

8. Did you have a problem with alcohol? . . . . Yes___ No___ (8)
   If yes, did CHRP help you to get over your alcohol problem? . . . . Yes___ No___

9. Did you need to find out the real cause of your health problem? . . . . Yes___ No___ (9)
   If yes, did CHRP help you to get to a specialist?. . . Yes___ No___

10. Did your health problems keep you from working?. . . . Yes___ No___ (10)
    If yes, did CHRP help you to realize that they didn't need to keep you from working? . . . . Yes___ No___

CHRP CLIENT EVALUATION p. 2

11. Did you have a problem with taking a lot of medicines
that you bought at the drug store without a prescription? Yes___ No___ (11)
If yes, did CHRP help you to realize this?. . . . . Yes___ No___

12. Did you have a problem with your appearance (grooming,
dress)? . . . . Yes___ No___ (12)
If yes, did CHRP help you with your appearance? . . . . . . Yes___ No___

13. Did you have a problem feeling good about yourself? . . . . Yes___ No___ (13)
If yes, did CHRP help you start feeling better about yourself? . . . . Yes___ No___

14. Did you used to think that other people didn't want to
help you with your problems? . . . . Yes___ No___ (14)
If yes, did you think after being a client of CHRP that
others did want to help? . . . . Yes___ No___

15. Did you get into a high school equivalency class? . . . . . Yes___ No___(15)
If yes, did CHRP help you get into the class? . . . . Yes___ No___

16. Did you get into job training?. . . . . Yes___ No___ (16)
If yes, did CHRP help you to get into job training? . . . . Yes___ No___

17. Did you learn how to present yourself at a job interview? . Yes___ No___ (17)
If yes, did CHRP help you learn what to do? . . . . Yes___ No___

18. Did you get a job?. . . . . Yes___ No___ (18)
If yes, did CHRP help you get a job?. . . . . Yes___ No___

19. Did you get into college? . . . . Yes___ No___ (19)
If yes, did CHRP help you get into college? . . . . Yes___ No___

20. Did you get child care? . . . . Yes___ No___ (20)
If yes, did CHRP help you get child care? . . . . Yes___ No___

CHRP CLIENT EVALUATION p. 3

21. Did you find the right agencies to help you with your problems?. . . . . Yes___ No___ (21)
If yes, did CHRP help you find these agencies? . . . . . . Yes___ No___

22. Did you need to get help with legal problems?. . . . . . . Yes___ No___ (22)
If yes, did CHRP help you get legal help?. . . . . Yes___ No___

23. Did you get transportation?. . . . . Yes___ No___ (23)
If yes, did CHRP help you get transportation?. . . . . . . Yes___ No___

24. Did you find a new place to live?. . . . . Yes___ No___ (24)
If yes, did CHRP help you find a new place to live?. . . . Yes___ No___

25. Does the health problem which prevented you from working still trouble you? . . . . Yes___ No___ (25)

26. Do you still need help from CHRP with respect to your health problem?. . . . . Yes___ No___ (26)

27. What service given by CHRP helped you most?______________________________

____

____

____

28. Was there any kind of help related to your health that you needed that you thought you did not get from CHRP? . . . . Yes___ No___ (28)
If yes, please explain:____

____

____

____

Cornell University
DIVISION OF NUTRITIONAL SCIENCES
Savage Hall
Ithaca, New York 14853

A DIVISION OF THE NEW YORK STATE COLLEGES OF
HUMAN ECOLOGY AND AGRICULTURE AND LIFE SCIENCES
Statutory Colleges of the State University of New York

LETTER TO U. S. SCHOOLS OF PUBLIC HEALTH AND GRADUATE PROGRAMS FOR COMMUNITY HEALTH EDUCATORS AND SCHOOLS OF ALLIED HEALTH.

Recent field research under my direction has identified a national problem in the lack of health education services for public assistance recipients, particularly those who are mandated to enter employment and job training programs.

The opportunity has now arisen to develop a system whereby a health educator could be introduced into selected manpower programs to offer counselling and health education to welfare clients.

We are therefore interested in learning about your health educator training program and particularly whether your graduates would have skills appropriate to the needs of the target population.

Perhaps you would be good enough to send us the prospectus, catalog and literature pertaining to your health education program and to answer the brief questionnaire which is attached. My associate has enclosed a stamped, self-addressed envelope for your convenience in returning the questionnaire.

Thanking you in advance for your assistance.

Sincerely,

Daphne A. Roe, M.D.

DAR/gac

CHRP Health Educator Questionnaire

School ______________________ Institution ______________________

1. What are the degrees offered by your program and what are the educational requirements for students entering each?

Degree offered	Educational requirements	Other academic preparation
Bachelors ____	____________	____________
Masters ____	____________	____________
Ph. D. ____	____________	____________

2. Is related work experience recommended and/or required or both?
   Recommended ____ Required ____ Both ____

3. For which of the following careers are your students prepared? (Check all that apply)

____ Health administration
____ Hospital administration
____ Public health social work
____ Maternal and child health
____ Public health education
____ Public health nutrition
____ Community mental health
____ Environmental health sciences
____ Biostatistics
____ Comprehensive health planning
____ Epidemiology
____ Biomedical laboratory sciences

____ Other (Please specify) ______________________________________

____

4. What are the usual salaries of graduates of your program on entering employment? (Please check)

Salary scale	B.A./B.S.	M.S./M.A.	M.P.H.	Ph. D.
Less than $8,000	____	____	____	____
$8,000 - $9,999	____	____	____	____
$10,000- $11,999	____	____	____	____
$12,000- $13,999	____	____	____	____
$14,000- $15,999	____	____	____	____
$16,000- and over	____	____	____	____

5. Does your health educator program include field work? Yes ____ No ____

   If yes,
   1) What is the length of time of field placement? ______________________
   2) What type of supervision is provided? ______________________
   3) In what type of agencies are students placed? ______________________

6. Do the students in your program have specific course and/or field work which would prepare them to work with welfare clients? Yes ____ No ____

   If yes, please specify- ______________________________________

   ____

APPENDIX F

REPORT FORMS (CLIENT)
TO REFERRING AGENCIES

REFERRAL

To: ____________

____

Re: ____________

____

____

FORM A

CORNELL HEALTH REHABILITATION PROJECT

☐ 401 South Avenue, Syracuse, N.Y.

☐ 225 South Fulton St. Ithaca, N.Y.

Date: ____________

Date of Physical Examination and Evaluation ____________

Presenting health complaints:

1. ____________ 4. ____________
2. ____________ 5. ____________
3. ____________ 6. ____________

Findings at examination:	Handicap	Work limitation indicated
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Referrals and/or Rehabilitation indicated:

1. ____________ 4. ____________
2. ____________ 5. ____________
3. ____________ 6. ____________

EMPLOYABILITY

YES

☐ No health problems found.

☐ No rehab. before job or job training.

☐ Rehab concurrent with job or job training.

NO

☐ Rehabilitation needed before job or job training. ________ months.

☐ Health problems too many or too severe.

- -

☐ Work limitation (see listing above)

Limitation considered to be ☐ temporary. ______ months.

☐ permanent.

- -

WAIVER FOR RELEASE OF MEDICAL INFORMATION: I have been advised of the results of the above evaluation and examination. Any referrals for treatment and/or rehabilitation have been explained to me. I hereby authorize the Cornell Health Project to disclose this information to DSS-WIN-OCETA-SETA who referred me. I understand that the information will be treated as confidential and will be used only for the purpose of aiding me in finding suitable employment.

____________ Signature

____________ Witness

____________ Examining Physician

☐ Selected randomly for intervention.

☐ Control. Advised of appointment on ____________

☐ Rejected. Reason checked below.

- ☐ No health problems
- ☐ Health problems too severe or too many
- ☐ Non health reasons
- ☐ Already receiving adequate care

☐ CHRP rejected by client

TO: WIN-DSS M
Onondaga County Civic Center
421 Montgomery Street
Syracuse, New York 13202

REPORT OF PHYSICAL EXAMINATION

CHRP
Cornell Health
Rehabilitation Project
225 South Fulton Street
Ithaca, New York 14850
401 South Avenue
Syracuse, New York 13204

RE: ______________________

____

Medicaid#________ Age____

REFERRAL RECEIVED________date

WAIVER FOR RELEASE OF MEDICAL INFORMATION: I hereby authorize the addressee to disclose to the Department of Social Services, any diagnosis made, or condition revealed, as a result of examination or treatment given me. I understand that the information will be treated as confidential and will be used only for the purpose of aiding me in finding suitable employment.

PERMISO PARA REVELAR INFORMACIÓN MÉDICA: Yo, por este medio, autorizo al destinatario que le dé al Departamento de Servicios Sociales alguna diagnosis hecha ó condición mastrada, como resultado de un examen ó tratamiento dado a mí. Yo entiendo que la información será tratada confidencial y usada solo por el propósito de ayudarme a consequir empleo.

SIGNATURE OF APPLICANT (FIRMA DEL SOLICITANTE)

SIGNATURE OF WITNESS (FIRMA DEL TESTIGO)

MEDICAL REPORT DIAGNOSIS	WORK LIMITATION INDICATED None	Temporary -90days	 +90days	Perm-anent	Unknown *	HANDICAP	WORK LIMITATION	REFERRAL AND/OR REHABILITATION
0. No positive findings								
1.								
2.								
3.								
4.								
5.								
6.								

FORM B

-245-

☐ Physical examination completed

☐ Final report pending completion of further investigations

*Health problem requires further investigation

________________Physician

________________date

EMPLOYABILITY

1. Capable of working
   - a. ☐ full time
   - b. ☐ part time
     - ___less than ½ time
     - ___more than ½ time
   - c. ☐ unable to work now

2. Work limitations
   - a. ☐ none
   - b. ☐ as stated above

3. Estimated date client can work or enter job training ___/___/___

4. Rehabilitation
   - a. ☐ none needed
   - b. ☐ yes, concurrent with employment or job training
   - c. ☐ yes, should precede employment or job training
   - d. ☐ severe permanent handicap(s)

FORM C

30 DAY REPORT ON YOUR CLIENT ____________________

TO: ____________________

ADDRESS ____________________

REFERRED TO CHRP ON ____________________

____

____________________ was selected at random for CHRP intervention in rehabilitation.

		APPOINTMENT			PROGRESS	
TREATMENT	DATE	KEPT	CANCELLED	NO SHOW	COMPLETED	TO BE CONTINUED

Intervention is expected to continue until ____________________

Client can enter job or job training on ____________________

Comments: ____________________

____

Cornell Health Rehabilitation Project
225 South Fulton Street
Ithaca, New York 14850

Signed ____________________
Title ____________________
Date ____________________

---

30 DAY REPORT

TO: ____________________

ON YOUR CLIENT ____________________

ADDRESS ____________________

REFERRED TO CHRP ON ____________________

____

____________________ was selected at random for CHRP intervention in rehabilitation.

		APPOINTMENT			PROGRESS	
TREATMENT	DATE	KEPT	CANCELLED	NO SHOW	COMPLETED	TO BE CONTINUED

Intervention is expected to continue until ____________________

Client can enter job or job training on ____________________

Cornell Health Rehabilitation Project
225 South Fulton Street
Ithaca, New York 14850

Signed ____________________
Title ____________________
Date ____________________

TO: ______________________

____

CHRP CASE COMPLETED

Cornell Health
Rehabilitation Project
225 South Fulton Street
Ithaca, New York 14850
401 South Avenue
Syracuse, New York 13204

RE: ______________________ DSS CASE # ________

______________________ CHRP CASE # ________

REFERRAL RECEIVED __________ DATE

CASE COMPLETED __________ DATE

LAST CHRP PHYSICAL EXAM __________ DATE

PRESENT WORK STATUS

☐ UNEMPLOYED
☐ EMPLOYED ☐ FULL TIME
☐ PART TIME

☐ CHOSEN AT RANDOM FOR CHRP INTERVENTION
(to receive help to overcome health problems, CHRP follow-up on health status, 3,6 & 9 mo.)

☐ CHOSEN AT RANDOM FOR CHRP CONTROL
(client advised of health problems and health services available. CHRP follow-up inquiry re health status at 3,6 & 9 mo.)

FINDINGS AFFECTING EMPLOYABILITY	REFERRAL AND/OR REHABILITATION INDICATED	COMPLETED	WORK LIMITATION AT PRESENT	
1.				
2.				
3.				
4.				
5.				
6.				

FORM D

REASON FOR COMPLETING - INTERVENTION CLIENT

☐ REHABILITATION COMPLETE
☐ INADEQUATE PARTICIPATION IN REHABILITATION
☐ NO LONGER AVAILABLE FOR REHABILITATION
  ☐ EMPLOYED ☐ UNKNOWN
  ☐ IN JOB TRAINING ☐ MOVED
  ☐ OTHER - specify ______________________

REASON FOR COMPLETING - CONTROL CLIENT

☐ PROJECTED TIME FOR REHABILITATION COMPLETE
  _/_/_ DATE OF LAST CHRP CONTACT

EMPLOYABILITY

1. CAPABLE OF WORKING
   a. ☐ FULL TIME
   b. ☐ PART TIME
      __LESS THAN ½ TIME
      __MORE THAN ½ TIME
   c. ☐ UNABLE TO WORK NOW
2. WORK LIMITATIONS
   a. ☐ NONE
   b. ☐ AS STATED ABOVE
3. ESTIMATED DATE CLIENT CAN WORK OR ENTER JOB TRAINING __/__/____

Please note CHRP records are available to social workers on this case. They include measurements of physical and psychological and social problems and progress, and in some cases may be useful in developing a plan for employment or training in job skills.

______________ PHYSICIAN

______________ DATE

APPENDIX G

CHRP CLIENT CHART

CONTACTS WITH CLIENT AND WITH PROFESSIONALS REGARDING CLIENT

Date	Information	Contact: 1. Phone 2. Personal 3. Transport 4. Letter	Initiated by: C. Client S Staff O. Other	Subject: M. Medical R. Referral J. Employment S. Support P. Psychological D. Dental	Time: Min. -15	Time: Min. 15-30	Time: Hrs.

Case #____

SCREENING CHECK LIST

____ Folder complete, case number on all sections, index card.

____ Agency Contacts - Job Training History

____ Work History

____ Physical Examination

____ Anthropometric Data

____ Medical History

____ Health Attitudes and Awareness

____ Food Frequency Interview

____ Drinking and Smoking Questionnaire

____ Life Setting Inventory

____ Psychological Testing Completed

____ I & E

____ Releases Signed

____ Participation Contract Signed ____ (date)

Place at back of folder when completed.

INFORMATION TO CLIENTS REFERRED TO
CORNELL HEALTH REHABILITATION PROJECT

You have been referred to us for a full evaluation of your health as it may affect your ability to work and participate in job training.

We will be seeing you on two occasions. Today we will be asking you questions about your health and at our next meeting you will have a physical exam and a number of other tests to assess your fitness. Laboratory tests will also be carried out.

You will receive a report of our findings and a similar report will be sent to the agency who referred you here.

Detailed information which you give us will be treated in a confidential manner.

It may be decided that you need help to overcome health problems. If you need such help, we may be able to offer services.

I have read this statement of the purposes of the Cornell Health Rehabilitation Project, and consent to this health evaluation.

________________________ ________________________

CORNELL HEALTH REHABILITATION PROJECT

401 South Avenue
Syracuse, New York 13202
474-6823

I CONSENT TO THE RELEASE OF MY MEDICAL RECORDS IN ORDER THAT THESE MAY BE REVIEWED BY THE DIRECTOR OF THE CORNELL RESEARCH PROJECT.

I UNDERSTAND THAT THESE RECORDS WILL NOT BE SHOWN TO UNAUTHORIZED PERSONS AND THAT THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

SIGNATURE ______________________
DATE ______________________
WITNESS ______________________

CORNELL HEALTH REHABILITATION PROJECT

401 South Avenue
Syracuse, New York 13202
474-6823

I CONSENT TO THE RELEASE OF MY MEDICAID RECORDS IN ORDER THAT THESE MAY BE REVIEWED.

I UNDERSTAND THAT THESE RECORDS WILL NOT BE SHOWN TO UNAUTHORIZED PERSONS AND THAT THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

SIGNATURE ______________________
DATE ______________________
WITNESS ______________________

CORNELL HEALTH REHABILITATION PROJECT

401 South Avenue
Syracuse, New York 13202
474-6823

I CONSENT TO THE RELEASE OF MY DENTAL RECORDS IN ORDER THAT THESE MAY BE REVIEWED BY THE DIRECTOR OF THE CORNELL RESEARCH PROJECT.

I UNDERSTAND THAT THESE RECORDS WILL NOT BE SHOWN TO UNAUTHORIZED PERSONS AND THAT THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

SIGNATURE ______________________
DATE ______________________
WITNESS ______________________

Case #____

AGENCY CONTACTS --- JOB TRAINING HISTORY

1. How did you find us?.
   a. through news media
   b. friends
   c. social agent
   d. employment agency
   e. other__________

2. Who decided you should come?
   a. self
   b. referring agent_____(indicate by # below)

3. Are you now registered with CETA?
   1. no
   2. yes. Date registered_____In what program?__________________________

4. Are you now registered with WIN?
   1. no
   2. yes. Date registered______In what program?__________________________

5. Have you worked or studied through a job training program in the past?
   1. no
   2. yes. Dates__________. Include details in Work History

6. What social agencies have you contacted in the last year?

	Who	How many times?
A. Social services (welfare)		
B. Social Security		
C. Family & Children's Service		
D. Cooperative Extension		
E. Employment service		
1. public (state, county)		
2. private		
F. Office of Vocational Rehabilitation		
G. Legal services		
1. public (i.e. Legal Aid)		
2. private (lawyer)		
H. Loan or finance company		
I. Other__________________		

7. SSI is a form of assistance to persons with a health problem.
   Have you ever applied for SSI?
   1. no
   2. yes
      a. you were accepted. Date ________
      b. you were rejected. Date ________

8. How long have you been receiving public assistance? ____years____total months
    a. AFDC
    b. HR
    c. SSI
    d. food stamps only
    e. Medicaid only

9. Have you been on welfare before this?
    1. no
    2. yes (ask #10)

10. Type of aid previously received:	When	Total months
1. AFDC	19__to19__	____
2. Aid to blind and disabled (SSI now)	19__to 19__	____
3. Home Relief	19__to 19__	____
4. Food stamps only	19__to 19__	____
5. Medicaid only	19__to 19__	____

11. Are you receiving Medicaid?
    1. no (if no, ask #12)
    2. yes. What is your current card number?____________

12. Have you ever applied for Medicaid?
    1. no. If not, why not?
        a. not eligible
        b. have another type of medical insurance
        c. don't want or need it
        d. don't know what it is
        e. don't know where to apply
        f. too many forms to fill out, or forms too complicated
        g. never thought about it
        h. other ________________________________
    2. yes. If yes, why don't you receive Medicaid?
        a. not eligible
        b. couldn't fill out forms or finish filling out forms
        c. forgot to re-file
        d. moved
        e. other________________________________

WORK HISTORY

1. Have you worked for pay? 1. no
2. yes (if 'yes' ask for work history, last job first and continue in that order)

A	B	C	D	E	F	G	H	I	J
1. Type of job 2. Place employed	Dates worked	Did you have a physical exam before getting job? 1. no 2. yes	Full time? code 40 hrs. Part time? code __#hrs.	Hourly pay: a. Up to $2.00 b. $2.01-$3.00 c. $3.01-$4.00 d. $4.01-$6.00 e. $over $6.00	If not paid hourly wages, approx. weekly, monthly, annual income (pref. before taxes)	Why did you leave this job? 00 haven't left 1 non-medical reason 2 medical reason NOT work related (ask J) a. illness c. other b. pregnancy (state) 3 medical, work induced* a. injured at work b. dermatitis c. fumes or dust d. other (state) 4 medical, work aggravated* (*ask H.I.J)	How easy was it to get another job? 1 I got one immediately It took: 2 3 mo. or less 3 6 mo. or less 4 9 mo. or less 5 one year 6 couldn't get a job. Why? (state below) 7 didn't try	(from G-3, G-4) Were you given another job in the same business or factory? 1 no 2 yes 3 didn't want one	(from G-2, G-3, G-4) Who made the decision that you leave the job? 1 I did 2 my doctor did 3 doctor at work 4 my employer 5 other (state below)
1. 2.	19__-19__ __months	____	____	____	$_____ per wk. mo. year (check one) Take home __ Gross __	____	____	____	____
1. 2.	19__-19__ __months	____	____	____	$_____ per wk. mo. year (check one) Take home __ Gross __	____	____	____	____
1. 2.	19__-19__ __months	____	____	____	$_____ per wk. mo. year (check one) Take home __ Gross __	____	____	____	____
1. 2.	19__-19__ __months	____	____	____	$_____ per wk. mo. year (check one) Take home __ Gross __	____	____	____	____
1. 2.	19__-19__ __months	____	____	____	$_____ per wk. mo. year (check one) Take home __ Gross __	____	____	____	____
1. 2.	19__-19__ __months	____	____	____	$_____ per wk. mo. year (check one) Take home __ Gross __	____	____	____	____

WORK HISTORY -255-

CASE #

WORK HISTORY, con't.

(circle one)

2. Last grade completed in school.......1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A. Age at leaving school _____ graduate school _____________

other education _____________

3. Does your work record reflect the kind of work you want to do?

1. no. State work goal.______________________________
2. yes

3-A Do you have any marketable skills that may not be reflected in your previous work experience?

1. no
2. yes (circle which skills)

a. typing
b. filing
c. bookkeeping

d. cooking
e. child care
f. driver

g. other ______________________
h. other ______________________

4. What is your work situation at present? (circle all that apply)

a. I am working now, for _______________ doing _______________
b. I am starting work, for _______________ doing _______________
c. I am in job training program (specify)_______________________
d. I am ready to work now.
e. I will be ready to work in 6 months.
f. I am looking for employment on my own.
g. I have gone to the employment service (which?)_______________
h. It will be longer than a year before I can work.
i. I may never be able to work. (reason)_______________________

5. The following is a list of reasons a person can't work. Which ones apply?

a. I have health problems.
b. I have personal (or family) problems.
c. I am too nervous.
d. I have transportation problems.
e. I have child care problems.
f. I need job skills.
g. Other ______________________

6. Does your health restrict the type of job you can get?

   1. no
   2. yes (ask the following:)

   Could you tell me the reasons why your health limits your employment?

	TRUE	FALSE
A. I cannot do a standing job because of my bad back.		
B. I cannot do a standing job because of my bad legs.		
C. I don't have good enough eyesight.		
D. I am hard of hearing.		
E. They won't hire people like me with skin complaints.		
F. I get nervous when I am working.		
G. I am lame or crippled.		
H. I get blackouts.		
I. I have bad teeth.		
J. I don't have teeth.		
K. I weigh too much.		
L. My doctor has told me not to take a job. a. Why? ____________________ b. For how long? __________		
M. Other ____________________		

7. Did you ever fail a physical exam given for a job?

   1. no
   2. yes

8. Would you like counseling on how to cope with employment?

   1. no
   2. yes

9. Would you like counseling on how to cope with nerves?

   1. no
   2. yes

10. Would you like help with your health?

   1. no
   2. yes

11. Does your health at present interfere with your working around the home?

   1. no
   2. yes. What is the problem? ____________________

      When did it start? __________

CASE #______

FACE SHEET

INITIAL PHYSICAL EXAM

DATE__________

A. POSITIVE FINDINGS

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

B. ORDERS FOR COMPLETION OF EVALUATION

____

____

____

____

____

____

____

C. INTRINSIC HANDICAPS

8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________

D. EXTRINSIC HANDICAPS

14. ______________________________
15. ______________________________
16. ______________________________
17. ______________________________
18. ______________________________
19. ______________________________

E. INTERVENTION INDICATED

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

E. Record of INTERVENTION AND REFERRALS

Problem # on Pg.1	Referred to:	Date initial visit	Date Report Received	What was done*	Date subsequent visits	Final Report

* a. evaluation only
b. evaluation & treatment
c. treatment only
d. physiotherapy
e. dental caries- repair
f. peridontal
g. extractions
h. dentures
i. surgical procedure
j. medical procedure
k. prothesis prescribed or fitted
l. psychological- individual
m. psychological- group
n. weight and diet
o. other____________________
p. other____________________
q. health education
r. medication

F. PSYCHOLOGICAL TEST SCORES

1. Wechsler ______ Date___________
2. 16PF ______ _____ _____
3. I & E ______ __________ client objection 1.no
2.yes
4. Hypochondriasis ______ __________
5. Life setting
   1. ___ Age
   2. ____ Number of children
   3. ____ Absence of man/woman
   4. ____ Education
   5. ____ Social/physical isolation
   6. ____ Cultural isolation
   7. ____ Welfare - institutional involvement
   8. ____ Stress
   9. ____ Disturbed family member
   10. ___ Work history

PHYSICAL EXAM

(Report positive findings - site and extent)

SKIN

1. acne ____
2. rash ____
3. cyanosis ____
4. hair loss ____
5. edema ____
6. varicose veins ____
7. other ____

HEAD AND NECK - A. MOUTH

8. lips ____
9. tongue ____
10. mucosa ____
11. halitosis ____

B. TEETH & GUMS

12. caries ____
13. peridontal disease ____
14. edentulous - upper ________________ lower ________________

C. EARS

15. outer ear ____
16. middle ear ____
17. other ____

D. NECK

18. goitre Yes ____ No ____. If yes, what is maximum neck circumference? ____________
19. other ____

E. EYES

20. ____

E. Record of INTERVENTION AND REFERRALS

Problem # on Pg.1	Referred to:	Date initial visit	Date Report Received	What was done*	Date subsequent visits	Final Report

* a. evaluation only
b. evaluation & treatment
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i. surgical procedure
j. medical procedure
k. prothesis prescribed or fitted
l. psychological- individual
m. psychological- group
n. weight and diet
o. other____________________
p. other____________________
q. health education
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5. Life setting
   1. ___ Age
   2. ___ Number of children
   3. ___ Absence of man/woman
   4. ___ Education
   5. ___ Social/physical isolation
   6. ___ Cultural isolation
   7. ___ Welfare - institutional involvement
   8. ___ Stress
   9. ___ Disturbed family member
   10. ___ Work history

PHYSICAL EXAM

(Report positive findings - site and extent)

SKIN

1. acne ______________________________

2. rash ______________________________

3. cyanosis ______________________________

4. hair loss ______________________________

5. edema ______________________________

6. varicose veins ______________________________

7. other ______________________________

HEAD AND NECK - A. MOUTH

8. lips ______________________________

9. tongue ______________________________

10. mucosa ______________________________

11. halitosis ______________________________

B. TEETH & GUMS

12. caries ______________________________

13. peridontal disease ______________________________

14. edentulous - upper ______________ lower ______________

C. EARS

15. outer ear ______________________________

16. middle ear ______________________________

17. other ______________________________

D. NECK

18. goitre Yes ___ No ___. If yes, what is maximum neck circumference? ______________

19. other ______________________________

E. EYES

20. ______________________________

CHEST

21. cough________________________________

22. breathlessness________________________________

23. deformity________________________________

24. heart________________________________

25. lungs________________________________

26. other________________________________

ABDOMEN

27. hernia________________________________

28. scars________________________________

29. other________________________________

MUSCULO-SKELETAL SYSTEM

30. deformity________________________________

31. loss of function________________________________

32. prosthesis worn________________________________

33. other________________________________

NERVOUS SYSTEM

34. tremor________________________________

35. paralysis________________________________

36. speech defect, aphasia________________________________

37. sensory abnormality________________________________

38. reflex abnormality________________________________

39. peculiar behavior during interview________________________________

COMMENTS:
(Not for use regarding information to be coded)

Instruction: Record physical findings on face sheet.

REGARDING EMPLOYMENT:

These physical findings:

0. would not interfere with working.

1. would limit work to part time. For how long?

2. with rehabilitation, would not interfere with working.

3. with rehabilitation, would limit type of job (circle limitations)
   - a. walking
   - b. climbing
   - c. standing
   - d. stooping, bending
   - e. sitting
   - f. lifting, carrying more than 25 lbs.
   - g. pushing, pulling
   - h. high rate of speed

4. would limit working conditions tolerated by client.

   Adverse conditions would be:
   - a. outside
   - b. high temperatures
   - c. low temperatures
   - d. sudden temperature change
   - e. skin irritants and allergens
   - f. dust
   - g. odors
   - h. high places
   - i. humid, wet
   - j. noise

CURRENT SYMPTOMS

	YES	NO
Rash		
Morning nausea		
Allergies		
Flatulence or indigestion		
Stomach pain		
Diarrhea		
Constipation		
Cough dry ☐ with sputum ☐		
Breathlessness on exertion ☐ at rest ☐		
Frequent tiredness		
Cramps in legs		
Palpitations		
Swollen ankles		
Frequent urination		
Urinary incontinence (inability to hold water)		
Frequent backache		
Flat feet		
Arthritis		
Insomnia		
Frequent nervousness		
Paralysis		
Frequent headaches		
Seizures		
Faintness		
Noises in ears or head		
Toothache		
Bleeding gums		
Tender gums		
- for women only -		
Prolapse (dropped uterus)		
Hot flashes		
Pregnancy DLMP ______		

I am going to read a list of statements about how you may feel. Please answer TRUE OR FALSE

T	F	
		1. I have few or no pains.
		2. I have little or no trouble with my muscles twitching or jumping.
		3. I am about as able to work as I ever was.
		4. My sleep is fitful and disturbed.
		5. I feel weak all over much of the time.
		6. I am troubled by attacks of nausea and vomiting.
		7. I have never vomited blood or coughed up blood.
		8. I hardly ever notice my heart pounding and I am seldom short of breath.
		9. I do not often notice my ears ringing or buzzing.
		10. Often I feel as if there were a tight band around my head.
		11. I am neither gaining nor losing weight.
		12. I wake up fresh and rested most mornings.
		13. My eyesight is as good as it has been for years.
		14. I am troubled by discomfort in the pit of my stomach every few days or oftener.
		15. I am in just as good physical health as most of my friends.
		16. I have a good appetite.
		17. I am very seldom troubled by constipation.
		18. During the past few years I have been well most of the time.
		19. I have numbness in one or more regions of my skin.
		20. There seems to be a fullness in my head or nose most of the time.
		21. I can read a long while without tiring my eyes.
		22. I am almost never bothered by pains over the heart or in my chest.
		23. I seldom or never have dizzy spells.
		24. I have a great deal of stomach trouble.
		25. The top of my head sometimes feels tender.
		26. I hardly ever feel pain in the back of the neck.
		27. I am bothered by acid stomach several times a week.
		28. I have had no difficulty in starting or holding my bowel movement.
		29. I have had no difficulty in keeping my balance in walking.
		30. Parts of my body often have feelings like burning, tingling, crawling, or like going to sleep.
		31. I have very few headaches.
		32. I do not tire quickly.
		33. My hands and feet are usually warm enough.

ANTHROPOMETRIC DATA

Case #____

Height______in.
Weight ______lbs.

Blood Pressure
1st reading __/___
2nd reading __/___

Temperature_________
Pulse ______________
Respiration ________

Mid arm circumference _____cm.
Triceps skinfold thickness _____mm.
_____mm.
_____mm.

GROSS MOTOR AGILITY
Time required to place blocks
in box _____min. _____sec.
_____task tolerated well.
_____complained.
_____unable to complete task.
comments__________________________

Lifting 10 lb. box to shelf
_____task tolerated well.
_____complained.
_____unable to lift box.
comments__________________________

Fine Motor Agility
_______number of dowel-cotter pin assemblies completed @ 2 min.
Comments__________________________

Smokes
no________
yes_________
_________-10 per day
_________+10 per day

Asthma
no_________
yes ________

Cold
no ________
yes_________
Other respiratory restrictions
(specify) ____________________
Vital capacity _________ _________

Dynamometer rt. arm _______
lt. arm _______

ANTHROPOMETRY

case#______

Step Test (Masters)

Heart Rate	Time (minutes)	No. of Ascents/Min.	Metronome Setting
________	0	0	0
________	3	8	50
________	6	12	72
________	9	16	100
________	12	20	120
________	13	0	0

Comments

______test tolerated well

______complained comments____.

______unable to complete test. Reason given__________________________.

Vision

1. Do you wear corrective lenses (glasses or contact lenses)?
   0. no
   1. only for reading
   2. only for driving
   3. sometimes
   4. all the time
2. If wearing glasses, test with glasses. Check if tested with contact lenses.______

Snellen Chart	Distance	left eye	________	Near	left eye	________
		right eye	________		right eye	________

Hearing

1. Do you wear a hearing aid?
   0. no
   1. yes

2. Able to hear spoken voice	Right ear	______	Left ear	______
Not able to hear spoken voice		______		______
Bone Conduction		______ Mastoid		______ Mastoid

ANTHROPOMETRIC DATA

Case #____

Height______in.

Weight ______lbs.

Blood Pressure

1st reading ___/___

2nd reading ___/___

Temperature__________

Pulse ________________

Respiration __________

Mid arm circumference ______cm.

Triceps skinfold thickness ______mm.

______mm.

______mm.

GROSS MOTOR AGILITY

Time required to place blocks in box ______min. ______sec.

______task tolerated well.

______complained.

______unable to complete task.

comments____________________________

Lifting 10 lb. box to shelf

______task tolerated well.

______complained.

______unable to lift box.

comments____________________________

Smokes

no__________

yes__________

__________-10 per day

__________+10 per day

Asthma

no__________

yes __________

Cold

no __________

yes__________

Other respiratory restrictions (specify) ____________________

Vital capacity __________ __________

Dynamometer rt. arm ________

lt. arm ________

Fine Motor Agility

________number of dowel-cotter pin assemblies completed @ 2 min.

Comments____________________________

ANTHROPOMETRY

case#______

Step Test (Masters)

Heart Rate	Time (minutes)	No. of Ascents/Min.	Metronome Setting
________	0	0	0
________	3	8	50
________	6	12	72
________	9	16	100
________	12	20	120
________	13	0	0

Comments

_____test tolerated well

_____complained comments___________________________________.

_____unable to complete test. Reason given_________________________.

Vision

1. Do you wear corrective lenses (glasses or contact lenses)?
   0. no
   1. only for reading
   2. only for driving
   3. sometimes
   4. all the time
2. If wearing glasses, test with glasses. Check if tested with contact lenses._____

Snellen Chart	Distance	left eye ________		Near	left eye__________
		right eye________			right eye ________

Hearing

1. Do you wear a hearing aid?
   0. no
   1. yes

2. Able to hear spoken voice	Right ear _______	Left ear________
Not able to hear spoken voice	_______	________
Bone Conduction	_______	________
	Mastoid	Mastoid

MEDICAL HISTORY

1. When were you born? ___month ___day ___ 19___

2. When you were born, did you have any medical problem?
   1. no
   2. yes
      A. What was the problem? Describe as fully as possible.______________________________

      ____

      B. Did your problem result in any permanent disability? (do NOT read catagories to patient)

0. no
1. poor sight
2. deafness, partial or full
3. cardiac disability
4. respiratory disability
5. mental retardation
6. crippled by inborn disease or congenital anomaly
7. late effect of birth injury (musculoskeletal)
8. other major chronic disabilities: CP, gross developmental defects
9. minor & unspecified including birthmarks digestive disturbances, etc.

3. Did you have any serious illness, operation or injury before the age of 6?
   1. no
   2. yes. What was the medical problem?

	PROBLEM 1	PROBLEM 2	PROBLEM 3	PROBLEM 4
A. Medical problem				
B. How long were you ill? 1. less than 6 months 2. more than 6 months				
C. Were you left with any permanent disability? 1. no 2. yes. Describe				
D. How many times did you have this problem before you were 6? 1. once 2. 2 - 3 times 3. recurrent incidents 4. continuously				

Case #

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4. Did you have any serious illnesses, operations or injuries as a school child and/or adolescent?

1. no
2. yes. What?

	PROBLEM 1	PROBLEM 2	PROBLEM 3	PROBLEM 4
A. What was the problem? (diagnosis to be recorded by MD)				
B. How long were you ill? 1. less than 6 months 2. more than 6 months				
C. Were you left with any permanent disability? 1. no 2. yes. Describe it (disability to be recorded by MD)				
D. How many times did you have this problem as a school child or adolescent? 1. once 3. recurrently 2. 2-3X 4. continuously				

5. What was the reason for your leaving school?

1. I graduated
2. They needed me at home
3. I got sick
4. I got pregnant
5. I went to work
6. I was injured
7. I got married
8. I dropped out
9. I moved
10. I was self conscious about my problem
11. I was in vocational training out of school
12. I am IN school
13. Other

6. Have you had any serious illnesses, injuries or operations since leaving school?
1. no
2. yes (record below)

Note: Space below dotted lines for use of MD to record ICDA codable terms.

	PROBLEM 1	PROBLEM 2	PROBLEM 3
A. What was the health problem?			
(diagnosis)	- - - - - -	- - - - - -	- - - - - -
B. When were you ill? For how long?	19_ ___months	19_ ___months	19_ ___months
C. How was medical care obtained?(name, if known)	1. hospitalization 2. saw a doctor	3. went to a clinic 4. went to an osteopath	5. went to hospital emergency room 6. other________________
	__	__	__
D. What was the treatment?	1. surgery 2. medical 3. rehabilitation a. psychological	b. physical therapy c. prosthetic device	d. weight reduction e. retraining for work
(details)	__	__	__
(procedure)	- - - - - -	- - - - - -	- - - - - -
E. Progress	1. full recovery 2. no progress, still have problem	3. recovering 4. left with a permanent disability	
(details)	__	__	__
(prognosis)	- - - -	- - - -	- - - -
F. How many times have you had this problem?	1. once 2. 2-3 times	3. recurrent incidents 4. continuously	
	__	__	__
G. Are you under a doctor's care now for this problem?	1. no 2. yes (name)	1. no 2. yes (name)	1. no 2. yes (name)
H. Did insurance pay for this problem?	1. no 2. yes (ask a-g) a. Private health ins. b. Medicaid	c.Workman's Compensation d.State Disability Ins. e.VA insurance	f.Company disability ins. g.Union disability ins. h.other____________
	__	__	__
7. Was this problem work related?	1. no 2. yes (ask I - L)	1. no 2. yes (ask I - L)	1. no 2. yes (ask I - L)
I. Are you still receiving payments from disability insurance?	1. no 2. yes	1. no 2. yes	1. no 2. yes
J. Did you lose your job because of this problem?	1. no. How long were you out sick?___weeks 2. yes. Why?______________	1. no.How long were you out sick?__weeks 2. yes Why?______________	1. no. How long were you out sick?___weeks 2. yes Why?______________
K. Does it still prevent you from doing your old job?	1. no 2. yes	1. no 2. yes	1. no 2. yes
L. Have you been employed since this problem?	1. no 2. yes	1. no 2. yes	1. no 2. yes
1.How long did it keep you from seeking employment?	_____months	_____months	_____months
2.How long were you unemployed?	_____months	_____months	_____months

Ask: Was there another serious illness, etc, during this time period?

8.a. ______ How many children do you have?

b. ______ How old is your youngest?

c. ______ How many children live with you?

FOR WOMEN ONLY - QUESTIONS #9 - 23

9. ______ How many pregnancies have you had?

10. ______ What was your age at your first pregnancy?

11. ______ How many miscarriages have you had?

12. ____ Have you had any children who were stillborn? (number)

13. ____ Have you had any children who were abnormal at birth?

14. Was your youngest child bottle or breast fed?
   1. bottle fed
   2. breast fed (for how long?)
      a. attempted for a short time
      b. less than 6 months
      c. 6-12 months
      d. more than 12 months

15. Did any medical problem during pregnancy, or any disability resulting from pregnancy ever prevent you from getting a job?
   1. no
   2. yes. What was it? ______________________________

   A. - or cause you to lose your job?
      1. no
      2. yes

16. Have you reached menopause?
   1. no
   2. yes (circle one) Was it after surgery (hysterectomy) or natural causes?

17. Do you use any contraceptive method?
   1. no
   2. yes What?
      a. I.U.D.
      b. Diaphragm or condom
      c. Foam
      d. Other chemical
      e. Tubal ligation
      f. Hysterectomy
      g. Pill

18. Have you ever taken birth control pills?
   1. no
   2. yes Ask questions 19-23

19. Are you taking birth control pills now?
    1. no
    2. yes (go to 21)

20. When did you take the pill? From _____ to _____

From _____ to _____ Total months _______

Name of pill(s) ____________________

Reason for discontinuing ____

21. How long have you been continuously on the pill you are now taking?

_____ months. What is its name? ______________________________

22. What other periods if any, have you taken this pill?

From _____ to _____

From _____ to _____ Total months _______

23. Have you taken any other pill?
    1. no
    2. yes. What? ________________________

24. Do you desire further assistance or advice in family planning?
    1. no
    2. yes

CHECKLIST

Did you forget to tell me about any illness, operation, injury during your life concerning your........

1. stomach, bowels, bladder?
2. heart, lungs or other internal organs?
3. nose, ears, throat?
4. eyes?
5. arms or legs, hands or feet?
6. skin?
7. teeth?
8. nervousness or mental problems?
9. female problems?

DRUG HISTORY

1. Do you take any medicines you buy at drugstore or pharmacy without a prescription or doctor's order?
   1. no
   2. yes. Ask:

2. For what complaints do you buy medicines? (use chart below)

3. What medicines do you buy?

4. How much do you need to give you relief?

2. Complaint	yes	no	3. Drug (medicine)	4. Dose	How often	How long
constipation						
headache						
nervousness						
insomnia						
upset stomach						
menstrual cramps						
colds, sinus trouble						
pain						
other (specify)						

5. Are you taking any medications at the present time that were prescribed by a doctor or dentist?

1. no
2. yes. (record below)

Type of medication	Proprietary Name	Or Generic Name	Duration of Intake	Frequency	Dose	Description, if Name unknown
Analgesics						
Antacids						
Bowel medicine, (except laxatives)						
Laxatives						
Sedatives						
Tranquilizers						
Diuretics						
Diet pills						
Cortisone & related						
Female hormones (not OCA)						
Thyroid						
Digitalis & other cardiovascular						
Antihypertensives						
Antihistamines						
Anticonvulsants						
Insulin & oral hypoglycemics						
Antibiotics & sulfa drugs						
Topical						
Nutrient supplements						

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25. What medical services have you used in the past year?

Title or kind	Name, Address (if known)	Medical coverage	Times seen
DOCTORS General Practitioner			
Specialists 1. Internist			
2. Gynecologist			
3. Surgeon			
4. Orthopedist			
5. EENT			
6. Dermatologist			
7. Psychiatrist			
8. Psychologist			
9. Other			
CLINICS Family Medicine Program At Cinema			
At Hospital			
Other Clinic*			
Hospital Emergency Room			
Hospital as In-Patient			
Dental Hospital for Extractions			

*Clinics:
1. Orthopedic
2. Chest
3. Speech & Hearing
4. Immunization
5. Family & Children's
6. Mental Health Clinic

HEALTH ATTITUDES AND AWARENESS

1. Do you have a regular family doctor; or clinic that you go to?
    1. no
    2. yes. Name____________________

2. When did you have a physical exam last?
    1. never
    2. more than 5 years ago
    3. within the last 5 years
    4. within the last year _____month

3. Who did it?
    1. your own doctor or the clinic you go to. Was it a...
        - a. routine physical exam?
        - b. visit for a special health problem? Specify__________________
    2. school doctor
    3. doctor for employment physical
    4. women's doctor
    5. other ____________________________

4. When you had your last physical exam, which of the following was done?
    1. blood pressure checked
    2. urine tested
    3. TB test...either skin test or chest X-ray
    4. hearing checked
    5. eyesight checked

5. Have you obtained advice from any family planning service?
    1. never
    2. within the last 5 years
    3. within the last year
    4. no, but I received advice from a doctor

6. When you are sick, (for example if you have a high fever) how soon do you see a doctor?
    1. Right away (if 'Right away, go to #8)
    2. After I've waited awhile (if answer is 2 - 5, ask #7)
    3. I put it off as long as possible.
    4. I never go to the doctor unless for an emergency.
    5. Other_______________________________________

7. Why do you delay going to the doctor?	TRUE	FALSE
1. I'm afraid the doctor might hurt me		
2. I'm anxious because he might find something seriously wrong		
3. I get embarrassed by physical examination		
4. I think doctors are prejudiced against people on welfare		
5. For religious reasons		
6. I think I can take care of myself		
7. It is very difficult to leave the children		
8. I don't have the use of a car		
9. There is no bus		
10. I can't afford it		
11. I can't get a doctor		
12. I find the doctor's office hours inconvenient		
13. Other ______________________________		

8. Has a doctor ever refused to treat you?

1. never
2. yes.
   a. you live too far away
   b. he was too busy
   c. you were/are getting public assistance
   d. you missed ___(#) appointments
   e. other______________________________
   f. racial discrimination
   g. don't know

9. Would you like to speak with a psychologist about your nerves or tension?

1. no
2. yes
3. I am seeing one now (only if subject volunteers this reply)
   a. Mental Health Clinic
   b. Family & Children's Service
   c. Private ____________________(name, if volunteered)

10. Do you have a regular family dentist...or clinic you go to?

1. no
2. yes. Name________________

11. When did you have a dental exam last?

1. never
2. more than 5 years ago
3. within the last 5 years
4. within the last year ______month

12. Who did it?
    1. dentist
    2. hygienist
    3. school check-up
    4. employment physical
    5. other____________________

13. When do you go to the dentist?
    1. When I have a toothache.
    2. When I see a decayed spot.
    3. When I have bleeding or sore gums.
    4. I have regular appointments each ___year...or ___times each year.
    5. When I want a tooth pulled.
    6. For special scheduled treatment.
    7. For denture work.
       a. new dentures
       b. adjustment
       c. replacement

14. Do you delay going to the dentist?
    1. no
    2. yes
       a. There are no dentists around here who accept Medicaid patients
       b. It is too expensive
       c. I am afraid he might want to take my teeth out
       d. I am waiting until it seems really necessary
       e. I can't leave the children
       f. I have transportation difficulties
       g. I am really afraid of going to the dentist
       h. The office hours are inconvenient for me
       i. I have difficulty scheduling appointments
       j. other_________________________________

15. Have you had your sight checked, other than for a driver's license?
    I. never
    2. more than 5 years ago
    3. within the last 5 years
    4. within the last year _____month

16. Who did it? Name, if known
    1. a doctor who specializes in eyes (Opthalmologist) ________________
    2. an optometrist or optician (fits, sells in his store) ________________
    3. your own doctor or clinic ________________
    4. at employment physical ________________
    5. at school ________________
    6. other ________________ ________________

17. Do you wear glasses?
    1. no
    2. yes
       a. when did you first get glasses? 19__
       b. when did you last have new glasses prescribed? 19__
       c. when did you last get new glasses? 19__

Case #______

FOOD FREQUENCY INTERVIEW

How many TIMES PER WEEK do you concume.....

	Circle correct number								More than 7 (specify)
Poultry	0	1	2	3	4	5	6	7	______
Fish and tunafish	0	1	2	3	4	5	6	7	______
Hot dogs and cold cuts	0	1	2	3	4	5	6	7	______
Liver	0	1	2	3	4	5	6	7	______
Other meats	0	1	2	3	4	5	6	7	______
Eggs	0	1	2	3	4	5	6	7	______
Cheese	0	1	2	3	4	5	6	7	______
Cottage cheese	0	1	2	3	4	5	6	7	______
Fruit juice	0	1	2	3	4	5	6	7	______
Raw fruit	0	1	2	3	4	5	6	7	______
Cooked vegetables	0	1	2	3	4	5	6	7	______
Raw vegetables (except lettuce)	0	1	2	3	4	5	6	7	______
Lettuce	0	1	2	3	4	5	6	7	______
Dried cooked beans and peas	0	1	2	3	4	5	6	7	______
Instant breakfast	0	1	2	3	4	5	6	7	______
Peanut butter	0	1	2	3	4	5	6	7	______
Nuts	0	1	2	3	4	5	6	7	______
Cereal breakfast foods	0	1	2	3	4	5	6	7	______
Potato chips or Fritos	0	1	2	3	4	5	6	7	______
Crackers or pretzels	0	1	2	3	4	5	6	7	______
Macaroni, spaghetti, rice, noodles	0	1	2	3	4	5	6	7	______
Potatoes (except French fries)	0	1	2	3	4	5	6	7	______
French fries	0	1	2	3	4	5	6	7	______
Candy bar or several candies	0	1	2	3	4	5	6	7	______
Ice cream	0	1	2	3	4	5	6	7	______
Cookies	0	1	2	3	4	5	6	7	______
Pie, cake	0	1	2	3	4	5	6	7	______
Doughnuts	0	1	2	3	4	5	6	7	______

How many servings PER DAY do you eat of the following.....

Bread, toast, rolls, sweet rolls, muffins (1 slice or 1 item is a serving)	0	1	2	3	4	5	6	7	______
Milk, including addition to other foods (8 ounces is a serving)	0	1	2	3	4	5	6	7	______
Butter or margarine (1 tsp. is a serving)	0	1	2	3	4	5	6	7	______

EATING HABITS

1. How many times A WEEK do you........

	Circle correct number								More than 7 (specify)
A. Eat breakfast	0	1	2	3	4	5	6	7	
B. Eat dinner 'out' (buy it)	0	1	2	3	4	5	6	7	
C. Eat dinner at home	0	1	2	3	4	5	6	7	
D. Have dinner with friends	0	1	2	3	4	5	6	7	
E. Buy prepared dinner to take home	0	1	2	3	4	5	6	7	
F. Pack your lunch	0	1	2	3	4	5	6	7	
G. Eat alone (any meal)	0	1	2	3	4	5	6	7	
H. Eat lunch out (buy it)	0	1	2	3	4	5	6	7	
I. Buy a candy bar or ice cream	0	1	2	3	4	5	6	7	
J. Miss lunch (or skip lunch)	0	1	2	3	4	5	6	7	
K. Miss dinner (or skip dinner)	0	1	2	3	4	5	6	7	
L. Have an evening snack	0	1	2	3	4	5	6	7	

2. Are you on a special diet?

    1. no
    2. yes. Is it to.........
        - A. lose weight
        - B. gain weight
        - C. for ulcer
        - D. control diabetes
        - E. control blood pressure
        - F. lower cholesterol
        - G. for anemia
        - H. other ______________

3. Are there certain foods you don't eat because they are too expensive?

    1. no
    2. yes. They are ____

4. Are there any foods you don't eat for reasons of your religion or beliefs?

    1. no
    2. yes. They are ____

5. Do you refuse to eat some foods because.......

A. they give you gas?
  1. no
  2. yes. What foods?______________________________

B. they give you heartburn?
  1. no
  2. yes. What foods?______________________________

C. they give you diarrhea?
  1. no
  2. yes. What foods?______________________________

D. they give you pain?
  1. no
  2. yes. What foods?______________________________

E. they give you a headache?
  1. no
  2. yes. What foods?______________________________

F. they are too fattening?
  1. no
  2. yes. What foods?______________________________

G. they are too acid?
  1. no
  2. yes. What foods?______________________________

H. they are too salty?
  1. no
  2. yes. What foods?______________________________

I. they cause acne?
  1. no
  2. yes. What foods?______________________________

J. for other reasons?
  1. no
  2. yes. What foods?______________________________

  What reasons?______________________________

FOOD PREFERENCES

	Like	Will Eat	Will Not Eat	Do Not Know
Beef				
Pork				
Veal				
Lamb				
Ham				
Chicken				
Turkey				
Luncheon meats				
Hot dogs				
Fish				
Tunafish				
Shellfish				
Eggs				
Fried				
Scrambled				
Boiled				
Peanut butter				
Nuts				
Bread, white				
Whole wheat				
Rye				
other______				
Cereals				
Hot cooked				
Cold				
Rice				
Pasta(spaghetti,etc				
Lettuce				
Romaine				
Endive				
Spinach				
Cucumber				
Broccoli				
Asparagus				
Green beans				
Peas				
Lima beans				
Corn				
Carrots				
Cole slaw				
Sauerkraut				
Cauliflower				
Beets				
Cooked cabbage				
Tomatoes				
Succotash				
Eggplant				
Turnips				
Collard greens				
Kale				
Mustard greens				
Wax beans				
Pickles				
Mushrooms				
Celery				
Squash				
Jam, Jelly				

	Like	Will Eat	Will Not Eat	Do Not Know
Potatoes, mashed				
Baked				
French fries				
Vegetable soup				
Bean soup				
Chili				
Baked beans				
Oranges				
Orange juice				
Grapefruit				
Grapefruit juice				
Fruit drink				
Cantalope				
Bananas				
Apples				
Plums				
Pears				
Grapes				
Apricots				
Pineapple				
Tomato juice				
V-8 Juice				
Honeydew melon				
Watermelon				
Applesauce				
Berries				
Fruit cocktail				
Peaches				
Cherries				
Dried fruit				
Whole milk				
Skim milk powd.				
Chocolate milk				
Cheese				
Cottage cheese				
Yogurt				
Butter				
Margarine				
Custard, pudding				
Ice cream				
Cake				
Pie				
Candy				
Cookies				
Popcorn				
Potato chips				
Pretzels				
Coffee				
Hot tea				
Iced tea				
Hot chocolate				
Soda pop				
Diet soda				
Lemonade				
Doughnuts				
Sweet rolls				
Crackers				

Case #______

DRINKING AND SMOKING
QUESTIONNAIRE

1. Do you drink: (circle one)
   - a. sweetened carbonated beverages
   - b. artifically sweetened carbonated beverages
   - c. both
   - d. none (go to question 5)
   - e. don't know which

2. How often do you drink sweetened and/or unsweetened carbonated beverages?
   - a. less than once a day
   - b. 1-3 times a day
   - c. 4-5 times a day
   - d. 6-8 times a day
   - e. 9-10 times a day
   - f. more than 10 times a day

3. When do you drink carbonated beverages? (circle 1 or more)
   - a. 7-11 A.M.
   - b. 11 A.M.-3 P.M.
   - c. 3-7 P.M.
   - d. 7-11 P.M.
   - e. 11 P.M.-3 A.M.
   - f. 3 A.M. - 7 A.M.

4. How much do you drink each day?
   - a. less than one glass per day
   - b. 1-3 glasses a day
   - c. 4-6 glasses a day
   - d. 7-8 glasses a day
   - e. 9-10 glasses a day
   - f. more than 10 glasses a day

5. Do you drink coffee?
   - 1. no (Go to queston 10)
   - 2. yes

6. How often do you drink coffee?
   - a. less than once a week
   - b. 1-3 times a week
   - c. 4-6 times a week
   - d. 1-3 times a day
   - e. 4-6 times a day
   - f. 7-9 times a day
   - g. 10 times a day
   - h. more than 10 times a day

7. When do you drink coffee? (circle one or more)
   - a. 7-11 A.M.
   - b. 11 A.M.-3 P.M.
   - c. 3-7 P.M.
   - d. 7-11 P.M.
   - e. 11 P.M.-3 A.M.
   - f. 3 A.M.- 7 A.M.

8. How much coffee do you drink each day? (circle one)
   - a. less than 1 cup
   - b. 1-3 cups a day
   - c. 4-6 cups a day
   - d. 7-9 cups a day
   - e. 10 cups a day
   - f. more than 10 cups a day

9. Do you drink coffee when you are:
   - a. tired
   - b. bored
   - c. thirsty
   - d. hungry
   - e. cold
   - f. nervous
   - g. relaxing
   - h. when you want to settle your stomach
   - i. when you are socializing (for example with friends)
   - j. when you want to stay alert and awake
   - k. other (specify)______________________
     (Go to question 11)

10. Why don't you drink coffee? (circle one or more)

a. don't like the taste
b. can't be bothered to make it
c. it's not good for you
d. keeps you awake
e. doctor told you not to drink it
f. never was interested
g. gives you bad breath
h. gives you an upset stomach
i. other (specify)_

11. Do you smoke cigarettes?

1. no (go to question 16)
2. yes

12. How many cigarettes do you smoke each day? (circle one)

a. less than ½ pack
b. ½ pack
c. ½- 1 pack
d. 1-1½ packs
e. 1½-2 packs
f. 2 -2½ packs
g. 2½-3 packs
h. more than 3 packs

13. When do you smoke? (circle one or more)

a. 7 - 11 A.M.
b. 11 A.M. - 3 P.M.
c. 3 - 7 P.M.
d. 7 - 11 P.M.
e. 11 P.M. - 3 A.M.
f. 3 - 7 A.M.

14. Do you smoke more when you: (circle one or more)

a. relax
b. have nothing better to do
c. are with people
d. are alone
e. go out (social)
f. are nervous
g. watch TV
h. are busy
i. are bored
j. before meals
k. after meals
l. weekdays
m. weekends
n. other (specify)_

15. Why do you smoke? (circle one or more)

a. out of habit
b. like the taste
c. calms your nerves
d. gives you something to do
e. makes you feel secure ('with it')
f. friends smoke
g. like to hold something in your hand
h. don't like to smoke, but can't stop
i. keeps you from overeating
j. other (specify)_
(go to question 17)

16. Why don't you smoke? (circle one or more)

a. don't like the taste
b. it's bad for you
c. it's too expensive
d. it stains your teeth
e. doctor told you not to smoke
f. don't like the smell
g. never were interested
h. makes you cough
i. gives you bad breath
j. religious reasons
k. other (specify)_

17. Do you drink alcoholic beverages?

    1. no (go to question 22)
    2. yes

18. How often do you drink alcoholic beverages? (circle one)

    a. less than once a week
    b. 1 - 3 times a week
    c. 4 - 6 times a week
    d. 1 - 3 times a day
    e. 4 - 6 times a day
    f. 7 - 9 times a day
    g. 10 times a day
    h. more than 10 times a day

19. What do you drink?

    (check appropriate box)

How many do you have?

	1	2	3	4	5	6	7	8	9	10	more than 10
a. Wine											
b. Beer											
c. Gin											
d. Vodka											
e. Whiskey											
f. Scotch											
g. Brandy											
h. Rum											
i. Other*											

*specify ______________________________

20. Do you drink more when you are: (circle one or more)

    a. by yourself
    b. with a group of people
    c. depressed
    d. nervous
    e. bored
    f. thirsty
    g. watching TV
    h. relaxing
    i. want to have a good time
    j. going out with other people
    k. angry
    l. lonely
    m. trying to get to sleep
    n. trying to settle your stomach
    o. other ______________________

21. Why do you drink? (circle one or more)

    a. out of habit
    b. like the taste
    c. like the feeling it gives you
    d. helps you forget your troubles
    e. gives you something to do
    f. your friends drink
    g. to be sociable
    h. makes you feel important ('with it')
    i. helps you sleep
    j. calms you down
    k. other______________________

22. (from question 17). Why don't you drink alcoholic beverages?

    a. don't like the taste
    b. not good for you
    c. don't like the effect on you
    d. doctor told you not to drink them
    e. too expensive
    f. religious reasons
    g. other______________________

Case #_____

LIFE SETTING INVENTORY

Part I - Family & Relative Data

1. Are you at present.....
   - A. married
   - B. single
   - C. divorced
   - D. separated. How often do you have contact with your spouse? (fill in one space)
     - 1. ___times per week
     - 2. ___times per month
     - 3. ___times per year
   - E. widowed
2. Are you planning to be married within the next year?
   - 1. no
   - 2. yes
3. How many persons live with you? _____
   - A. Some general information will be helpful. We need to know.....

	Age	Relationship	Marital Status	Work Status	Public Assistance
		a.child b.spouse c.friend 1.m,2.f d.parent 1.m,2.f e.in-law 1.m,2.f f.other________ g.other________	m s d sep w	a.working-contributes to household support b.working-no contribution to house support c.not working* (ask B*) d.school e.job training f.other__________	a. is receiving P.A. b. was receiving P.A. c. has applied for P.A. d. has SSI e. has OVR f. other __________ g. other __________
1.					
2.					
3.					
4.					
5.					
6.					
7.					

B*. Why doesn't he/she work? (indicate person by number from chart above)

(check as many as apply for each)	Person__	Person__	Person__	Person__
1. can't find a job				
2. not trained to work				
3. aged				
4. physically or emotionally unable to work				
Can you explain the problem?				
a.late effects of injury or operation				
b.an acute medical problem				
c.a chronic medical problem				
d.a mental problem (other than retardation)				
e.alcoholism				
f.mental retardation				
g.was in prison				
h.other ________________				
i.other ________________				

4. Are all the children in your home of school age (5 - 18) in regular school?

   1. no (ask A)
   2. yes (go to question 5)

      A. How many are not? _____ What is the reason?

(check as many as apply)

	Child Age ____	Child Age ____	Child Age ____
1. Special school or training program (identify)			
2. Child needed to help at home			
3. Mental retardation			
4. Trouble with the law			
5. Working at a job			
6. Dropped out - not working			
7. Other. physical problems ..... (identify)			

   3. Does not apply. No school age children.

5. Is any member of your family at present in an institution?

   1. no
   2. yes. What kind of institution is it?

A. Kind	B. Institution Name, if client is willing	C. Age of person
1. Mental hospital	______________________________	___
2. Jail	______________________________	___
3. Foster care	______________________________	___
4. School for retarded	______________________________	___
5. Hospital	______________________________	___
6.. Other __________	______________________________	___

6. Has anyone living with you been released from such an institution in the past 6 months?

   1. no
   2. yes. What was it?

      A. Mental hospital
      B. Jail
      C. Foster care
      D. School for retarded
      E. Hospital
      F. Other __________

7. How did you support yourself just before you applied for public assistance?

   A. My parents supported me.
   B. I worked.
   C. My spouse worked.
   D. Other ________________

8. When you were 10, who did you live with...that is, who was primarily responsible for you?

   A. One parent. 1.m 2.f
   B. Both parents
   C. One grandparent 1.m 2.f
   D. Both grandparents
   E. Other relative.
   F. Other, non-relative

9. What was the breadwinner's occupation when you were 10?

   A. ____
   B. Was not working.

LIFE SETTING INVENTORY

Part II - Living Arrangements

1. How long have you lived where you are now?

   A. under 3 months
   B. under 6 months
   C. under 1 year
   D. under 5 years
   E. 5 years or more

2. Do you expect to move within the next year?

   1. no
   2. yes
   3. don't know

3. Are you happy with your present living arrangements?

   1. no
   2. yes

4. Do you live in a .....

   A. house
   B. trailer
   C. apartment
   D. hotel or motel
   E. other____________

5. How many times have you moved.....

   A. in the last year?_____
   B. in the last two years?_____

6. Who owns your home? (if answer is A or B go to #7)
   (if answer is C go to #8)

   A. the landlord
   B. the Public Housing Authority
   C. you do. Do you still make payments on a mortgage?
      1. no
      2. yes

7. Who pays the rent?

   A. You do
   B. Welfare
   C. Other family or persons living with you
   D. Combination of above. ____ and ____
   E. Other______________________________

8. How many living units are in your building?

   A. 1 D. 5 - 6
   B. 2 E. 7 or more
   C. 3 - 4

9. How many rooms do you live in?

   A. One. Are your meals included? (room and board)
      1. no
      2. yes

      Do you have cooking privilèges?
      3. no
      4. yes

   B. Two

   C. Three

   D. Four

   E. Five or more. State ______

10. Do you share a kitchen with another living unit?

    1. no
    2. yes. How many persons share it? _____

11. Do you share a bathroom with another living unit?

    1. no
    2. yes. How many persons share it? _____

12. How many beds in your home? _____

13. Regarding transportation....(circle answers most true for you)

    A. You have access to a car you can drive (but don't own it)

    B. A family member drives you where you need to go.

    C. You drive the family car.

    D. You own your own car.

    E. You depend on others for basic transportation.
       1. Where you live, a car is really necessary.
       2. Where you live, most people use public transportation.

14. Regarding telephones.....

    A. you do have one.

    B. You don't have one, but people can call you at a friend's number.

    C. There is no phone available where people can call you.

15. Do you have a T.V.?

    1. no
    2. yes

LIFE SETTING INVENTORY
Part III- Interests & Activities

1. Are you a member of any groups or clubs?
   1. no
   2. yes. Are they..... (circle as many as apply, specify where possible)
      - A. a lodge?
      - B. a sports club or league?
      - C. a neighborhood or friends' group?
      - D. a church or church group?
      - E. a special group?....______________________________
        1. Cooperative Extension
        2. Girl Scouts
        3. 4-H
        4. Boy Scouts
        5. Volunteer fire worker
        6. Auxiliary - to__________
        7. Other __________
        8. Other __________

2. Do you have any hobbies?
   1. no.
   2. yes. What are they? (circle as many as apply, specify where possible)
      - A. Gardening, Flowers
      - B. Gardening, vegetables
      - C. Handcrafts
        1. sewing
        2. knitting, crocheting
        3. refinish furniture
        4.
        5.
      - D. Doing puzzles
      - E. Cooking
      - F. Sports
      - G. Painting, artwork
      - H. Writing
      - I. Fishing
      - J. Hunting
      - K. Music
        1. listening
        2. making music and listening
      - L. Other__________________
      - M. Other__________________

3. What do you like to do in your free time? (circle as many as apply)
   - A. My group or club activities
   - B. My hobbies
   - C. Play games of chance....gamble
   - D. Play games that are not gambling
   - E. Walk
   - F. Watch TV
   - G. Go to__________________
   - H. Other__________________

4. Which of your choices in # 3 do you spend the most time doing? (indicate by letter)
   - A. ___(most time)
   - B. ___(next most time)
   - C. ___

5. Who do you turn to when you need emotional support? (circle as many as apply)
   - A. Your spouse
   - B. Your parent
   - C. A child
   - D. Your minister or priest
   - E. A friend
   - F. GOD
   - G. Other relative
   - H. Someone in an agency (social worker, __________________Counselor)
   - I. Doctor
   - J. Your pet
   - K. No one

Case #_____

MARK AN X in the box for one of the two choices for each number.

1. A. ☐ Children get into trouble because their parents punish them too much.
   B. ☐ The trouble with most children nowadays is that their parents are too easy with them.

2. A. ☐ Many of the unhappy things in people's lives are partly due to bad luck
   B. ☐ People's misfortunes result from the mistakes they make.

3. A. ☐ One of the major reasons why we have wars is because people don't take enough interest in politics.
   B. ☐ There will always be wars, no matter how hard people try to prevent them.

4. A. ☐ In the long run people get the respect they deserve in this world.
   B. ☐ Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. A. ☐ The idea that teachers are unfair to students is nonsense.
   B. ☐ Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. A. ☐ Without the right breaks one cannot be an effective leader.
   B. ☐ Capable people who fail to become leaders have not taken advantage of their opportunities.

7. A. ☐ No matter how hard you try, some people just don't like you.
   B. ☐ People who can't get others to like them don't understand how to get along with people.

8. A. ☐ Heredity plays the major role in determining one's personality.
   B. ☐ It is one's experience in life which determines what they're like.

9. A. ☐ I have often found that what is going to happen will happen.
   B. ☐ Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. A. ☐ In the case of the well prepared student, there is rarely if ever such a thing as an unfair test.
    B. ☐ Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. A. ☐ Becoming a success is a matter of hard work, luck has little or nothing to do with it.
    B. ☐ Getting a good job depends mainly on being in the right place at the right time.

12. A. ☐ The average citizen can have an influence on government decisions.
    B. ☐ This world is run by the few people in power, and there is not much the little guy can do about it.

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13. A. ☐ When I make plans, I am almost certain that I can make them work.
    B. ☐ It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

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14. A. ☐ There are certain people who are just no good.
    B. ☐ There is some good in everybody.

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15. A. ☐ In my case getting what I want has little or nothing to do with luck.
    B. ☐ Many times we might just as well decide what to do by flipping a coin.

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16. A. ☐ Who gets to be the boss often depends on who was lucky enough to be in the right place first.
    B. ☐ Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

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17. A. ☐ As far as world affairs are concerned, most of us are the victems of forces we can neither understand nor control.
    B. ☐ By taking an active part in political and social affairs the people can control world events.

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18. A. ☐ Most people don't realize the extant to which their lives are controlled by accidental happenings.
    B. ☐ There really is no such thing as 'luck'.

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19. A. ☐ One should always be willing to admit mistakes.
    B. ☐ It is usually best to cover up one's mistakes.

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20. A. ☐ It is hard to know whether or not a person really likes you.
    B. ☐ How many friends you have depends on how nice a person you are.

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21. A. ☐ In the long run the bad things that happen to us are balanced by the good ones.
    B. ☐ Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

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22. A. ☐ With enough effort we can wipe out political corruption.
    B. ☐ It is difficult for people to have much control over the things politicians do in office.

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23. A. ☐ Sometimes I can't understand how teachers arrive at the grades they give.
    B. ☐ There is a direct connection between how hard I study and the grades I get.

24.	A. ☐ A good leader expects people to decide for themsleves what they should do.	B. ☐ A good leader makes it clear to everybody what their jobs are.
25.	A. ☐ Many times I feel that I have little influence over the things that happen to me.	B. ☐ It is impossible for me to believe that chance or luck plays an important role in my life.
26.	A. ☐ People are lonely because they don't try to be friendly.	B. ☐ There's not much use in trying too hard to please people, if they like you, they like you.
27.	A. ☐ There is too much emphasis on athletics in high school.	B. ☐ Team sports are an excellent way to build character.
28.	A. ☐ What happens to me is my own doing.	B. ☐ Sometimes I feel that I don't have enough control over the direction my life is taking.
29.	A. ☐ Most of the time I can't understand why politicians behave the way they do.	B. ☐ In the long run the people are responsible for bad government on a national as well as on a local level.

DATE OF EVALUATION __________ ID # __________________
DATE OF REPORT __________ NAME __________________

CHRP-EVALUATION

EVALUATION PROCEDURES & SCORES

BETA REVISED EXAMINATION ______
HYPOCHONDRIASIS SCALE ______
ROTTER I & E ______
16 PF-OUTSTANDING THEMES: ______________________________

PREVIOUS PSYCHIATRIC SERVICES AND/OR HOSPITALIZATIONS

PLACE: 1 ______________________ DATE ______________
2 ______________________ DATE ______________

PHYSICAL DESCRIPTION (include sex, age, marital status, ethnicity, dress, hygiene, physical disabilities, interview behavior)

PRESENT AVAILABLE SOCIAL OR PSYCHOLOGICAL RESOURCE

(contact before admission)

Providers Name ______________ Phone Number ______________
Type of Service ______________ How Long ______________
Brief History of Service ______________________________

MENTAL STATUS:

SPEECH ______________________________
MOOD ______________________________
AFFECTIVE STATES ______________________________
THOUGHT PROCESSES ______________________________
DISORDERS OF PERCEPTION ______________________________
INTELLECTUAL FUNCTIONING ______________________________
ORIENTATION ______________________________
MEMORY ______________________________
JUDGEMENT/INSIGHT ______________________________

APPRAISAL of PROBLEMS

(Rating Scale: 0 = None, 1 = Mild, 2 = Moderate, 3 = Marked)

PHYSICAL FUNCTION

1___Sleep Problems
too much or too little

2___Eating Problems
too much or too little

3___Speech Articulation Problem

4___Other Physical Problems

SOCIAL RELATIONS DISTURBANCE

5___With Children

6___With Mate, Spouse

7___With Other Family

8___With Other People

SOCIAL PERFORMANCE DISTURBANCE

9___School

10___Job

11___Housekeeping

OTHER SIGNS & SYMPTOMS

12___Suicidal Thoughts

13___Suicidal Gestures,Acts

14___Anxiety, Fears, Phobias

15___Obsessions, Compulsions

16___Depressed Mood, Inferiority

17___Somatic Concerns, Hypochondriasis

18___Social Withdrawal, Isolation

19___Dependency Clining

20___Grandiosity

21___Suspicion, Persecution

22___Delusions

23___Inappropriate Affect, Appearance,Behavior

24___Hallucinations

25___Anger,Belligerance

26___Assultive Acts

27___Alcohol Abuse

28___Narcotics, Other Drugs

29___Antisocial Attitudes, Acts

30___Sexual Problems

31___Agitation, Hyperactivity

32___Disorientation, Impaired Memory

33___Slowed up, Lack of Emotion

34___Daily Routine, Leisure Time

35___Overall Severity of Condition

NARRATIVE SUMMARY (referral, current life setting, precipitating problem, current Hx, significant past Hx, employment Hx and/or education, etc.).

NARRATIVE SUMMARY:

RECOMMENDATION:

EVALUATED BY: ______________________ TITLE: ______________________